85-2048

No. .....

Supreme Court, U.S.
FILED
JUN 9
JOSEPH F. SPANIOL, JR.
CLERK

In The

Supreme Court of the United States

October Term, 1985

Supreme Court, U.S.
FILED
JUN 9 1986
JOSEPH F. SPANIOL, JR.
CLERK

LENORD S. HORWITZ, D.P.M.,
Appellant,

vs.

THE STATE BOARD OF MEDICAL EXAMINERS OF THE STATE OF COLORADO and THE PEOPLE OF THE STATE OF COLORADO, ex rel. DUANE WOODARD, Attorney General,
Appellees.

ON APPEAL FROM THE SUPREME COURT OF THE STATE OF COLORADO

JURISDICTIONAL STATEMENT

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the actions of a state licensing board in (a) summarily suspending a licensee's professional license to practice without affording the licensee any prior notice or opportunity to be heard, and (b) thereafter continuing such summary suspension for over ninety days after issuance of an initial decision favorable to the licensee on the merits, violates a licensee's rights to due process of law under the 14th Amendment to the United States Constitution.

2. Whether the licensing provisions of the Colorado Administrative Procedures Act are unconstitutional insofar as they may authorize a summary suspension without affording the licensee prior notice or opportunity to be heard and insofar as they authorize the continuation of such suspension for an indeterminate and perhaps excessively long period of time.

LIST OF PARTIES

The following were parties to the proceeding in the Colorado Supreme Court which denied *certiorari* to review the decision of Colorado Court of Appeals, to wit: Lenord S. Horwitz, D.P.M., Respondent-Appellant; The State Board of Medical Examiners of the State of Colorado ("Board"), and the People of the State of Colorado, ex rel. Duane Woodard, Attorney General, Petitioners-Appellees.

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THE STATE BOARD OF MEDICAL EXAMINERS OF THE STATE OF COLORADO and THE PEOPLE OF THE STATE OF COLORADO, ex rel. DUANE WOODARD, Attorney General,
Appellees.

—o—

ON APPEAL FROM THE SUPREME COURT OF THE STATE OF COLORADO

—o—

JURISDICTIONAL STATEMENT

—o—

Lenord S. Horwitz, D.P.M. ("Horwitz"), the Appellant, appeals from the Order of the Colorado Supreme Court of March 19, 1986, denying Appellant's Petition for Writ of Certiorari to review the decision of the Colorado Court of Appeals entered in *Lenord S. Horwitz, D.P.M. v. State Board of Medical Examiners of the State of Colo-*

rado, et al., rendered on June 27, 1985, and the subsequent Final Judgment entered on March 23, 1986. Horwitz submits this Jurisdictional Statement to show that this Court has jurisdiction of the Appeal and that a substantial question is presented requiring plenary consideration and oral argument.

———o———

OPINIONS BELOW

The Opinion of the Colorado Court of Appeals on the underlying merits, reported at 716 P.2d 131 (Colo. App. 1985), is reprinted at Appendix A, p. App. 1, *infra*. The Order of the Colorado Supreme Court denying Horwitz' Petition for Writ of Certiorari, dated March 17, 1986, is reprinted at Appendix B hereto, p. App. 13, *infra*.

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JURISDICTION

This proceeding involves a challenge by Horwitz under the Fourteenth Amendment to the United States Constitution to the disciplinary action taken against his license to practice podiatry by the Colorado State Board of Medical Examiners ("Board"), purportedly under the Colorado Administrative Procedures Act, C.R.S. 24-4-101, et seq. The Colorado Court of Appeals upheld portions of the Board's disciplinary orders. The Mandate of the Court of Appeals was entered on March 23, 1986 and is reprinted at Appendix C hereto, p. App. 15, *infra*.

The Colorado Supreme Court denied Horwitz's Petition for Writ of Certiorari and thereby declined to con-

sider the constitutional issues raised before the Colorado Court of Appeals. The denial of the Petition for Writ of Certiorari by the Colorado Supreme Court to review such constitutional issues is an affirmance of the judgment of the Colorado Court of Appeals and may constitute grounds for review by the United States Supreme Court. *Williams v. Bruffy*, 102 U.S. 248, 26 L.Ed. 135 (1880).

The Notice of Appeal to this Court was filed with the Clerk of the Colorado Court of Appeals and the Clerk of the Colorado Supreme Court on June 6, 1986. The Notice of Appeal is attached hereto to Appendix D, p. App. 16, *infra*.

The jurisdiction of this Court to hear this Appeal rests upon 28 U.S.C. § 1257, which provides as follows:

> "Final judgments or decrees rendered by the highest court of a state in which a decision could be had, may be reviewed by the Supreme Court as follows: . . .
>
> (2) By appeal where is drawn in question the validity of a statute of any state on the ground of its being repugnant to the Constitution, treaties or laws of the United States, and the decision is in favor of its validity."

———o———

STATUTE INVOLVED

The statute involved in this Appeal is C.R.S. 24-4-104, which is reprinted at Appendix E, p. App. 18.

———o———

STATEMENT OF THE CASE

This action arises out of the imposition by the Colorado State Board of Medical Examiners of disciplinary sanctions against Dr. Lenord Horwitz' license to practice podiatry in the State of Colorado. On July 15, 1983, Horwitz, having successfully defended on the merits approximately 15 charges of unprofessional conduct, entered into a Stipulation with the Board by which two remaining counts were dismissed with prejudice under the condition that Horwitz allow the record-keeping and surgical aspects of his practice to be supervised. Dr. Stephen Albert was appointed to act as the supervisor.

Commencing in September, 1983, Dr. Albert began submitting monthly reports to the Board concerning his observation and supervision of Horwitz' practice. Although his reports were critical of aspects of Horwitz' record-keeping practices, there were no problems observed with regard to Horwitz' surgical practice, and in fact, Dr. Albert noted that based upon Dr. Albert's limited observation, Horwitz' surgical practice and technique were at acceptable levels of quality.

On December 1, 1983, Dr. Albert gave a verbal report to the Board in which he accused Horwitz of gross negligence and labeled Horwitz as a danger to the public. On the same date the Board met with Dr. Horwitz and his counsel to ascertain whether more surgical observations by Dr. Albert could be scheduled. The Board did not advise Horwitz of the nature of Dr. Albert's accusations or even that accusations had been made. On the same date the Board voted unanimously to summarily suspend Hor-

witz' license to practice podiatry, conditioned upon the receipt by the Board of a written report from Dr. Albert.

A written report was received on December 12, 1983. A Formal Complaint was issued on December 21, 1983, along with an Order of Summary Suspension against Horwitz' license. The Board gave Horwitz no prior notice of the imposition of sanctions or of the institution of formal charges. The Board conducted no prefiling investigation and gave Horwitz no opportunity for input, formal or informal, prior to the imposition of the suspension. In fact, the Board did not even meet after December 1, 1983 to review Dr. Albert's written report.

A full hearing on the merits commenced on January 19, 1984 before a Board-appointed Hearing Officer. The hearing was completed on January 25, 1984. The Hearing Officer's Initial Decision was rendered on February 6, 1984, which Decision found in favor of Horwitz with regard to 42 of the 44 numbered paragraphs contained in the Formal Complaint. The matters found to have been committed by Horwitz were found to be relatively minor. No discipline was recommended, and in fact, it was recommended that Horwitz be immediately reinstated to his practice.

Horwitz requested the Inquiry Panel of the Board and the Hearing Panel of the Board to reinstate him to his license to practice on three occasions, which requests were all denied. Finally, on May 11, 1984, the Colorado Court of Appeals allowed Horwitz to resume his practice. The Hearing Panel on said date imposed one year of probation on Horwitz as the discipline warranted by the Board's finding of unprofessional conduct. The Formal

Complaint and Order of Summary Suspension are appended as Appendix F hereto, p. App. 22; the Initial Decision of the Hearing Officer is Appendix G hereto, p. App. 42; and the Board's Order of Discipline is Appendix H hereto, p. App. 61.

Horwitz appealed the Board's Order to the Colorado Court of Appeals on several grounds, chief among which were that the Order of Summary Suspension was issued in excess of the Board's jurisdiction and violated Horwitz' rights to due process of law; or alternatively, that C.R.S. 24-4-104, the portion of the Colorado Administrative Procedures Act under which the Order of Summary Suspension was ostensibly issued, is unconstitutional since it allows for the imposition of a suspension without either notice to the licensee or opportunity of the licensee to be heard prior to the suspension and since the statute allows for a licensee to remain under suspension for more than a reasonable length of time.

The Colorado Court of Appeals disagreed, and held that the Order of Summary Suspension did not violate Horwitz' due process rights and, by implication, that the statute was constitutional. The Court of Appeals denied Horwitz' Petition for Rehearing and the Colorado Supreme Court denied his Petition for Writ of Certiorari.

THE QUESTION IS SUBSTANTIAL

The question of the power of a state regulatory agency to take summary action against a licensee, without any prior notice to the licensee and without any opportunity

afforded to the licensee for input or to be heard is of paramount importance.

This Court has pronounced on this subject on many different occasions. Most recently, in *Cleveland Board of Education v. Loudermill*, 470 U.S. ——, 84 L.Ed.2d 494, 105 S.Ct. 1487 (1985), this Court held that, in the context of the termination of government employment, due process mandates notice and opportunity to be heard prior to the termination.

In *Matthews v. Eldridge*, 424 U.S. 343, 47 L.Ed.2d 18, 96 S.Ct. 893 (1976), the Court required notice and opportunity to be heard prior to adverse agency action even though the affected individual received a full evidentiary hearing subsequent to the action being taken.

In a directly analogous situation, *Barry v. Barchi*, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642, (1979), this Court held that pretermination (pre-suspension) procedures were sufficient if they notify the licensee of the charges and give him the opportunity to present his side of the story. However, this Court found the subject statute constitutionally defective because it could not guarantee that the licensee would not remain under suspension for an unreasonably long period of time.

In the present case, the statute fails on both pre-suspension and post-suspension grounds. The statute, C.R.S. 24-4-104(4), does not allow for any pre-suspension notice or opportunity to be heard. Therefore, if an agency need not comply with C.R.S. 24-4-104(3) prior to imposing a summary suspension, as found by the Colorado Supreme Court and the Colorado Court of Appeals, then the Colorado Administrative Procedures Act expressly authorizes a

board or agency to suspend a license without even a modicum of pre-suspension due process.

Then, after the licensee is suspended, as the present case so amply demonstrates, a licensee must remain under suspension for some indeterminate time during which a hearing is scheduled and held; a second indeterminate time period during which an initial decision is issued; thirty days to allow the parties to file exceptions; and a further indeterminate period of time for the Hearing Panel to issue its final Order. C.R.S. 24-4-105 (14) and (15), which is reprinted as Appendix I hereto, p. App. 81.

If the decisions of the Colorado Supreme Court and the Colorado Court of Appeals are correct, then the Colorado statutory scheme apparently authorizes an agency to suspend a license without substantial basis and without even the barest of knowledge on the part of the licensee; to subject the licensee to a hearing on unfounded charges, and then to keep the licensee under suspension for at least thirty additional days after the hearing to allow the *government prosecutor* to file exceptions. Such a scheme cannot be constitutional.

These are not hypothetical or speculative fears. In the present case, the licensee *was* suspended without his knowledge; the charges were substantially unfounded, and were based upon a verbal, ex parte and undocumented report; the licensee was substantially acquitted after hearing and yet he had to remain under suspension for four months for conduct which was found to be serious enough to warrant only probation.

The due process clause of the Fourteenth Amendment to the United States Constitution is an empty promise if it

cannot protect an individual from such unilateral, arbitrary and capricious governmental action. The Colorado statute which authorizes such outrage cannot be in conformity with the Constitutional mandate of due process of law.

This Court has, many times in the past, stricken down statutes which cause a violation of a private citizen's due process rights. This is not a new or novel concept but is firmly rooted in our system of jurisprudence.

CONCLUSION

For the foregoing reasons, this Court should note probable jurisdiction of this Appeal.

In the alternative, Appellant prays that this Court construe this Jurisdictional Statement as a Petition for Writ of Certiorari pursuant to 28 U.S.C. § 2103.

Respectfully submitted,

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APPENDIX A

Lenord S. HORWITZ, D.P.M.,

Petitioner,

v.

COLORADO STATE BOARD OF MEDICAL EXAMINERS, and the People of the State of Colorado, ex rel. Duane Woodard, Attorney General,

Respondents.

No. 84CA0541.

Colorado Court of Appeals,
Div. I.

June 27, 1985.

Rehearing Denied Nov. 21, 1985.
Certiorari Denied (Horwitz)

March 17, 1986.

Podiatrist was placed on one year probation from practice, subject to supervision and other requirements by State Board of Medical Examiners, and he appealed. The Court of Appeals, Enoch, C.J., held that: (1) Board properly suspended podiatrist's license summarily; (2) Board's orders were not tainted with unlawful appearance of unfairness; (3) finding that podiatrist did not properly sterilize swabs was erroneous; (4) podiatrist engaged in deviations from standard of care; and (5) supervision of podiatrist by medical doctors and osteopaths was improper.

Affirmed in part, set aside in part and remanded.

Hochstadt, Straw & Strauss, P.C., Jordan Hochstadt, Richard S. Strauss, Denver, for petitioner.

Duane Woodard, Atty. Gen., Charles B. Howe, Chief Deputy Atty. Gen., Richard H. Forman, Sol. Gen., Thomas J. Lyons, Asst. Atty. Gen., Denver, for respondents.

ENOCH, Chief Judge.

Petitioner, Lenord S. Horwitz, a podiatrist, appeals from an order of the State Board of Medical Examiners (Board) which placed his practice on one-year probation, subject to supervision and other requirements. We set aside in part and remand.

The Board is divided into two panels when conducting disciplinary proceedings. Section 12-36-118(1), C.R.S. (1984 Cum.Supp.). One panel is designated an "inquiry panel," the other a "hearings panel." Upon receipt of a written complaint, the inquiry panel investigates and determines whether there are sufficient grounds for a hearing. Section 12-36-118(4), C.R.S. (1984 Cum.Supp.). The hearings panel may then conduct an evidentiary hearing, or may appoint a hearing officer to conduct the hearing subject to its review. Section 12-36-118(1) and (5), C.R.S. (1984 Cum.Supp.). The hearing panel's report of its findings and conclusions, when approved and signed by a majority of the members of the panel who have conducted the hearing, becomes the action of the Board. Section 12-36-118(5)(g)(I), C.R.S. (1984 Cum.Supp.). When appropriate, the hearing panel is mandated to determine the extent of discipline within the statutory guidelines. Section 12-36-118(5)(g)(III), C.R.S. (1984 Cum.Supp.).

On July 15, 1983, petitioner and the Board entered into a stipulation which provided that two charges of unprofessional conduct which had been brought would be dismissed with prejudice in return for petitioner's agree-

ment to complete 40 hours of continuing podiatric education in the area of surgery, to have his surgical practice supervised by an ambulatory foot surgeon, and to have his record-keeping supervised by a podiatrist. Dr. Albert, a podiatrist, was appointed to serve in both capacities.

On December 1, 1983, at a meeting with the inquiry panel to discuss scheduling difficulties, Dr. Albert was asked his opinion of petitioner's standard of care. He stated that in his opinion, because of poor technique and gross negligence, petitioner was a danger to the health, safety, and welfare of the public. After receiving these new charges, detailed in writing, the inquiry panel instructed the Attorney General to file a new complaint against petitioner, and on December 21, 1983, an order summarily suspending his license was entered.

A hearing was held before a hearing officer, and on February 6, 1984, the officer found two deviations from the standard of care: that X-rays were not available until surgery had virtually been started, and that a culture plate was left exposed to the air for one to three hours prior to incubation. Nevertheless, he recommended that petitioner's license be immediately reinstated, that no further discipline be imposed as a result of the charges, and that petitioner's supervision under the stipulation continue. Despite that recommendation, both the inquiry panel and the hearing panel denied petitioner's request to vacate the summary suspension.

Exceptions were filed to these findings, and after a hearing before the hearing panel it entered its final order on May 1, 1984. The panel affirmed the hearing officer's factual findings but found that the weight of the evidence

supported an additional finding that the procedure used to sterilize swabs did not render them sterile and, thus, failed to meet generally accepted standards of care. It was ordered that he should be granted probation on the condition that supervision of his practice by podiatrists be continued, and that he commit no acts or omissions that constitute substandard medical care during the probationary period. Further, the suspension of his license was to be lifted as soon as he found Board approved supervisors.

On May 3, 1984, this court ordered the Board to locate and approve, by May 11, 1984, a podiatrist or podiatrists to supervise the petitioner's practice and to specify the terms and conditions of the probation. On May 10, the Board issued a supplemental order which appointed four podiatrists as observers, and stated probationary conditions that included the completion of courses in surgery, anesthetics, and aseptic technique. After this order was issued, petitioner demonstrated to this court that these podiatrists were unwilling to serve. On July 20, 1984, the Board amended its supplemental order to include the names of four new observers, only one of which was a podiatrist. Following this Board action, we granted petitioner's motion for stay pending this appeal.

I.

Petitioner first contends that the Board lacked jurisdiction to enter its order because they were procedurally defective and violated his right to due process of law. He argues that the Board failed to follow the notice and hearing requirements of § 24-4-101 and §§ 12-32-101, et seq, C.R.S. (Colorado Podiatry Act), and §§ 12-36-101, et

seq., C.R.S. (Colorado Medical Practices Act). We do not agree.

Colorado State Board of Medical Examiners v. District Court, 191 Colo. 158, 551 P.2d 194 (1976) specifically held that § 24-4-104(4), C.R.S., authorizes the Board to suspend summarily a license to practice medicine when it has reasonable grounds to believe that the public health, safety, or welfare is endangered, that emergency action is required, and the Board has incorporated such findings into its order. Furthermore, *Colorado State Board* rejected a due process argument similar to the one made by petitioner here.

The record supports the Board's determination that it had reasonable grounds to believe that emergency action was required. Although eventually most of the allegations were not proven, the Board was initially faced with the fact that 44 complaints had been lodged against petitioner by the Board-appointed supervisor. The Board's action was thus reasonably taken pursuant to its statutory authority under § 24-4-104(4), C.R.S., and that action is entitled to a presumption of validity and constitutionality which has not been overcome. *See Mitchell v. Charnes*, 656 P.2d 719 (Colo.App.1982).

Petitioner has cited to the court the recent case of *Cleveland Board of Education v. Loudermill*, 470 U.S. —, 105 S.Ct. 1487, 84 L.Ed.2d 494 (1985), as support for his contention that § 24-4-104(4), C.R.S., violates his due process rights. Contrary to his contention, the Supreme Court in *Loudermill*, and the cases cited therein, continues to recognize that emergency action in certain cases, such as we have here, where the public welfare and safety may

be affected, is not a violation of one's due process rights. The decision in *Loudermill, supra,* in our view does not affect the holding of *Colorado State Board, supra.*

Petitioner argues alternatively that even if the Board had the authority to suspend his license summarily, it failed to follow required procedures in so doing, and erred in not lifting the suspension after the hearing officer's initial findings. We disagree.

In *Colorado State Board, supra,* the Supreme Court rejected a similar argument that in cases of summary suspension statutory notice and hearing is required. In such cases the Board is required to provide the opportunity "for an ultimate judicial determination within a reasonably prompt time." *Colorado State Board, supra. See also Barry v. Barchi,* 443 U.S. 55, 99 S.Ct. 2642, 61 L.Ed.2d 365 (1979).

Here, petitioner concedes that the Board accorded him virtually an immediate hearing on the merits of the complaints. There is nothing in the record to indicate that the Board delayed its determination in any way, or that its final determinations were not reasonably prompt. *See Loudermill, supra.* Furthermore, because exceptions were filed to the hearing officer's initial findings, and because the findings explicitly stated that supervision of petitioner's practice should continue, and that the supervisor had resigned, it was not unreasonable, nor an abuse of discretion, for the Board to allow the suspension to continue.

II.

Petitioner next contends that the Board's orders are tainted with an unlawful appearance of unfairness by its

consultation with the "Conflicts Counsel" from the Attorney General's office, and with an allegedly biased Podiatry Board. We find no merit in these contentions.

The Attorney General's office is required to serve both as the Board's counsel, and to prosecute charges before hearing panels and provide representation in support of Board decisions. To avoid the appearance of impropriety and to maintain the integrity of the administrative process, the regulatory law section and conflicts counsel has been separated within the attorney general's office. *Cf. Osborn v. District Court,* 619 P.2d 41 (Colo. 1980). Additionally, a Board's actions are entitled to a legal presumption of regularity and validity, *Mitchell, supra,* which petitioner did nothing to overcome. Furthermore, petitioner concedes that there is no reason to believe that conflicts counsel participated in the deliberations of the Board.

Nor is there evidence that petitioner was prejudiced in any way by the Board's mandatory consultation with the Podiatry Board. *See* § 12-32-104, C.R.S. A fair hearing had already been accorded him prior to any consultation, *see McGee v. State Board of Accountancy,* 169 Colo. 87, 453 P.2d 800 (1969), and, unlike his prior hearing, petitioner presented no evidence to demonstrate that the Podiatry Board was still biased against him. Thus, petitioner failed to overcome the presumption of regularity.

III.

Petitioner also contends that the Board's orders are based on erroneous factual determinations, contrary to the weight of the evidence. We agree in part, but hold that any error is harmless.

The issue here concerns the Board's finding that petitioner did not properly sterilize swabs used in his practice, even though the hearing officer had found that the evidence did not support the complaint on this matter. This decision by the Board was erroneous because the hearing officer's contrary finding of evidentiary fact was supported by competent evidence. *See* § 24-4-105(15)(b), C.R.S. (1982 Repl.Vol. 10); *Lee v. State Board of Dental Examiners,* 654 P.2d 839 (Colo.1982).

The error is harmless, however, because the hearing officer found, and the Board affirmed, that petitioner had engaged in two deviations from the standard of care. Section 12-32-107(3)(i), C.R.S. (1984 Cum.Supp.) states that unprofessional conduct is defined as "two or more acts or omissions which fail to meet generally accepted standards of the practice of podiatry," and § 12-32-107(2), C.R.S., allows the Board to revoke or suspend the license to practice podiatry of one guilty of unprofessional conduct. Thus, an erroneous determination that the petitioner had participated in three acts which deviated from the standard of care, as opposed to two, does not affect the Board's ability to impose sanctions.

IV.

Petitioner next contends that there is no reasonable relationship between the conditions of probation imposed by the Board in its supplemental order and the unprofessional conduct which it found had been committed. We agree in part.

Section 12-36-118(5)(g)(III), C.R.S. (1984 Cum.Supp.) provides that when the Board finds charges have been proven it may order a podiatrist to continue to practice

under probation, and may include in such order the probationary conditions it deems appropriate to assure that petitioner practices in accordance with generally accepted professional standards. Here, it was established that petitioner had engaged in unprofessional conduct because of two deviations from the standard of care, § 12-32-107(3)(i), C.R.S., and it is thus not unreasonable for the Board to require continued observation. Section 12-36-118 (5)(g)(III)(C), C.R.S., provides that one condition of probation may be "the review of supervision of his practice as may be necessary *to determine the quality of his practice* and to correct deficiencies therein." (emphasis added)

Although the Board has ordered the observation of areas of petitioner's practice which were not found substandard, the Board is empowered by its finding of unprofessional conduct to oversee petitioner's practice and determine the extent of such conduct. The Board has discretion in disciplinary matters, and we cannot say as a matter of law that it has abused its discretion here. *Cardamon v. State Board of Optometric Examiners,* 165 Colo. 520, 441 P.2d 25 (1968).

We agree, however, that the Board abused its discretion as a matter of law in requiring petitioner to complete courses in the area of surgery, anesthetics, and aseptic technique because there were no supportable findings from the hearing of substandard conduct in these areas. Section 12-36-118(5)(g)(III)(B), C.R.S. (1984 Cum.Supp.) states that as a probationary condition the Board may require one to take "such . . . course of training or education *as may be needed to correct deficiencies* as may be found . . . *in the hearing.*" (emphasis added) Hence, the language of this subsection requires that any courses instituted as a proba-

tionary condition must be for the purpose of correcting a specific deficiency found in the hearing.

Here, the Board did make a finding at the hearing that petitioner's aseptic procedures were substandard because of the evidence concerning the improperly sterilized swabs. However, we have held in part III of this opinion that this finding was in error. Thus, there is no valid finding to support the order of the educational requirements in aseptic techniques and procedures.

It was also an abuse of discretion for the Board to have required petitioner to complete a course in anesthetics and surgery as a probationary condition, because there were no findings of deficiencies as a result of the hearing concerning these procedures. This holding, however, does not affect petitioner's obligation to complete 40 hours of continuing podiatric education in the area of surgery, which was part of the 1983 stipulation. The stipulation specifically states that any future Board findings do not stay its requirements.

V.

Petitioner contends that the Board's appointment in its amended supplemental order of observers who are not podiatrists is improper because the medical doctor and doctors of osteopathic medicine who will be observing and determining the quality of his practice will be unable to do so under the appropriate standard of care. We agree.

As previously stated, the Board is allowed to appoint observers to determine the quality of petitioner's practice to enable it to correct deficiencies therein. However, the quality of a medical practice is determined according to the standard of care used by those in the same field. *Connelly v. Kortz*, 689 P.2d 728 (Colo.App.1984). And, in general

practitioners of one school of medicine are not competent to testify as to the standards of care of another. *Caro v. Bumpus,* 30 Colo. App. 144, 491 P.2d 606 (1971). Thus, the standard of care is the degree of skill that is customarily observed by practitioners of podiatry, and not the standards of practice or methods of practices of other schools of medicine. *See Caro v. Bumpus, supra.*

We thus hold that the Board abused its discretion when it appointed two osteopathic doctors and a medical doctor to serve as observers for the petitioner's practice.

VI.

Petitioner's contention that the failure of Board members to take an oath of office renders its proceedings null and void is without merit. *See Hedstrom v. Motor Vehicle Division,* 662 P.2d 173 (Colo. 1983).

Nor do we find that the Board's appointment of observers under its supplemental orders was the result of bad faith or was intended to harass or delay, and thus, we disagree with petitioner's contentions in this regard and deny his request for attorneys' fees. *See Mission Denver Co. v. Pierson,* 674 P.2d 363 (Colo. 1984); C.A.R. 38(d).

The Board's order which conditioned the petitioner's probation upon the completion of courses in anesthetics, aseptics, and surgery is set aside. However, as previously stated, this holding does not affect petitioner's obligation to take courses in surgery as specified in the original stipulation of July 1983. In all other respects the order is affirmed. The cause is remanded to the Board for the limited purpose of appointment of observers who have been trained in the field of podiatry. Copies of the written order of ap-

pointment and acceptance by the observers shall be certified and forwarded immediately to this court. The court will then reconsider its stay order, which shall remain in effect until further order of court. In the event the certified copies have not been filed with the court within 30 days of this opinion, the Board shall, in writing, advise the court of the status of the proceedings.

PIERCE and BABCOCK, JJ., concur.

APPENDIX B

SUPREME COURT, STATE OF COLORADO

Case No. 85SC492

Certiorari to the Colorado Court of Appeals 84CA0541
Appeal, State Board of Medical Examiners

RG ME DAAED

ORDER OF COURT

(Filed March 17, 1986)

LENORD S. HORWITZ, D.P.M.,

Petitioner,

v.

COLORADO STATE BOARD OF MEDICAL EXAMINERS and THE PEOPLE OF THE STATE OF COLORADO, ex rel. DUANE WOODARD, Attorney General,

Respondents.

Upon consideration of the Petition for Writ of Certiorari to the Colorado Court of Appeals, and after review of the record, the briefs, and the opinion of said Court of Appeals,

IT IS THIS DAY ORDERED that said Petition for Writ of Certiorari shall be, and the same hereby is, DENIED.

BY THE COURT, EN BANC, MARCH 17, 1986.

CHIEF JUSTICE QUINN does not participate.

cc: Gary Sonke, Clerk
Colorado Court of Appeals

Hochstadt, Straw & Strauss, P.C.
Jordan Hochstadt
Richard S. Strauss
2043 York Street
Denver, CO 80205

Duane Woodard, Attorney General
Charles B. Howe, Chief Deputy Attorney General
Richard H. Forman, Solicitor General
Thomas J. Lyons, Assistant Attorney General
1525 Sherman Street, 2nd Floor
Denver, CO 80203

State Board of Medical Examiners
c/o Thomas J. Beckett, Program Administrator
1525 Sherman Street, Room 130
Denver, CO 80203

APPENDIX C

Appeal from the Board of Medical Examiners to the Colorado Court of Appeals. Opinion issued & judgment entered 6/27/85, before Enoch, C.J., Pierce & Babcock, JJ.

STATE OF COLORADO
COURT OF APPEALS

2 East Fourteenth Avenue, Suite 300
Denver, Colorado 80203
(303) 861-1111

LENORD S. HORWITZ, D.P.M.,

Petitioner,

-v-

COLORADO STATE BOARD OF MEDICAL EXAMINERS and THE PEOPLE OF THE STATE OF COLORADO, ex rel. DUANE WOODARD, Attorney General,

Respondents.

MANDATE

(Filed March 21, 1986)

Court of Appeals No.

Trial Court No.

This cause came to be heard on the record on appeal from the Colorado Board of Medical Examiners, and was argued by counsel, on consideration thereof, it is ordered that the Judgment of the Board of Medical Examiners is affirmed in part, set aside in part, and cause remanded with directions.

GARY SONKE
Clerk of Court

/s/ by: Melissa Cloud
Deputy Court Clerk

APPENDIX D

SUPREME COURT, STATE OF COLORADO

Case No. 85 SC 492

NOTICE OF APPEAL TO THE
UNITED STATES SUPREME COURT

LENORD S. HORWITZ, D.P.M.,

Appellant,

vs.

THE STATE BOARD OF MEDICAL EXAMINERS OF THE STATE OF COLORADO, THE PEOPLE OF THE STATE OF COLORADO, ex rel. DUANE WOODARD, ATTORNEY GENERAL,

Appellees.

NOTICE is hereby given that Lenord S. Horwitz, D.P.M., the Appellant above-named hereby appeals to the Supreme Court of the United States from the Order of the Colorado Supreme Court of March 19, 1986, denying Appellant's Petition for Writ of Certiorari to review the decision of the Colorado Court of Appeals entered in *Lenord S. Horwitz, D.P.M. v. State Board of Medical Examiners of the State of Colorado, et al.*, rendered on June 27, 1985, and the subsequent Final Judgment entered by the Colorado Court of Appeals on March 23, 1986.

This appeal is taken pursuant to 28 U.S.C. § 1257 and 28 U.S.C. § 2103.

Respectfully Submitted,

HOCHSTADT, STRAW & STRAUSS, P.C.

/s/ by: Jordan Hochstadt, No. 106
Richard S. Strauss, No. 7916

Attorneys for Appellant
2043 York Street
Denver, Colorado 80205
(303) 329-9222

CERTIFICATE OF FILING

I HEREBY CERTIFY that I have this 6th day of June, 1986 filed a true and correct copy of the foregoing Notice of Appeal with the Clerk of the Supreme Court of the State of Colorado and with the Clerk of the Court of Appeals of the State of Colorado.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have this 6th day of June, 1986 placed a true and correct copy of the foregoing Notice of Appeal in the United States Mails, postage prepaid thereon, addressed to:

Duane Woodard, Attorney General
Charles B. Howe, Chief Deputy Attorney General
Richard H. Forman, Solicitor General
Thomas J. Lyons, Assistant Attorney General
1525 Sherman Street, 2nd Floor
Denver, Colorado 80203

State Board of Medical Examiners
c/o Thomas J. Beckett, Program Administrator
1525 Sherman Street, Room 103
Denver, Colorado 80203

APPENDIX E

24-4-104. Licenses - issuance, suspension or revocation, renewal. (1) In any case in which application is made for a license required by law, the agency, with due regard for the rights and priveleges of all interested persons, shall set and conduct the proceedings in accordance with this article unless otherwise required by law.

(2) Every agency decision respecting the grant, renewal, denial, revocation, suspension, annulment, limitation, or modification of a license shall be based solely upon the stated criteria, terms, and purposes of the statute, or regulations promulgated thereunder, and case law interpreting such statutes and regulations pursuant to which the license is issued or required. Terms, conditions, or requirements limiting any license shall be valid only if reasonably necessary to effectuate the purposes, scope, or stated terms of the statute pursuant to which the license is issued or required.

(3) No revocation, suspension, annulment, limitation, or modification of a license by any agency shall be lawful unless, before institution of agency proceedings therefor, the agency has given the licensee notice in writing of facts or conduct that may warrant such action, afforded the licensee opportunity to submit written data, views, and arguments with respect to such facts or conduct, and, except in cases of deliberate and willful violation, given the licensee a reasonable opportunity to comply with all lawful requirements.

(4) Where the agency has reasonable grounds to believe and finds that the licensee has been guilty of deliberate and willful violation or that the public health, safety,

or welfare imperatively requires emergency action and incorporates such findings in its order, it may summarily suspend the license pending proceedings for suspension or revocation which shall be promptly instituted and determined.

(5) A proceeding for the revocation, suspension, annulment, limitation, or modification of a previously issued license shall be commenced by the agency upon its own motion or by the filing with the agency of a written complaint, signed and sworn to by the complainant, stating the name of the licensee complained against and the grounds for the requested action.

(6) No previously issued license shall be revoked, suspended, annuled, itteed, or modified, except as provided in subsection (3) of this section, until err hearing as provided in section 24-4-105.

(7) In any case in which the licensee has made timely and sufficient application for the renewal of a license or for a new license for the conduct of a previously licensed activity of a continuing nature, the existing license shall not expire until such application has been finally acted upon by the agency, and if the application is denied, it shall be treated in all respects as a revocation.

(8) An application for a license shall be acted upon promptly, and immediately after the taking of action on such application by an agency, a written notice of the action taken by the agency and, if the application is denied, the grounds therefor shall be given to the applicant. The giving of such notice shall be by personal service upon the applicant or by mailing the same to the address of

the applicant as shown on the application or as subsequently furnished in writing by the applicant to the agency.

(9) If an application for a new license is denied without a hearing, the applicant, within sixty days after the giving of notice of such action, may request a hearing before the agency as provided in section 24-4-105, and the action of the agency after any hearing shall be subject to judicial review as provided in section 24-4-106.

(10) Written notice of the revocation, suspension, annulment, limitation, or modification of a license and the grounds therefor shall be served forthwith on the licensee personally or by mailing by first-class mail to the last address furnished the agency by the licensee.

(11) A limitation, unless consented to by the applicant, on a license applied for shall be treated as a denial. A modification, unless consented to by the licensee, of a license already issued shall be treated as a revocation.

(12) In an appropriate case a revoked or suspended license may be reissued.

Source: L. 59, p. 161, § 3; C.R.S. 53, § 3-16-3; C.R.S. 1963, § 3-16-3; L. 69, p. 84, § 4; L. 81, p. 1141, § 1.

24-4-104. Licenses - issuance, suspension or revocation, renewal. (6) No previously issued license shall be revoked, suspended, annuled, limited, or modified, except as provided in subsection (3) of this section, until after hearing as provided in section 24-4-105.

(13) (a) Any applicant who, under oath, supplies false information to an agency in an application for a license commits perjury in the second degree, as defined

in section 18-8-503, C.R.S. Any such application shall bear notice, in accordance with section 18-8-501 (2) (a) (I), C.R.S., that false statements made therein are punishable.

(b) On and after January 1, 1985, an agency shall not require that information contained in an application for a license be affirmed to before a notary.

Source: (13) added, L. 83, p. 521, § 4.

Editor's note: Subsection (6) is reprinted for reenactment to correct errors made in the preparation of the 1982 Replacement Volume in which the word "limited" was erroneously printed "itteed" (2nd line) and the word "after" was erroneously printed as "err" (last line).

APPENDIX F

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS

STATE OF COLORADO

Proceeding No. RG ME DAAED

FORMAL COMPLAINT OF THE ATTORNEY GENERAL

PEOPLE OF THE STATE OF COLORADO *ex rel.* DUANE WOODARD, ATTORNEY GENERAL,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

COME NOW the People of the State of Colorado *ex rel. Duane Woodard,* attorney general of the State of Colorado ("complainant"), and make this complaint against Lenord S. Horwitz, D.P.M. ("respondent"), pursuant to the provisions of C.R.S. 1973, 12-36-118(5)(a) and at the direction of inquiry panel A of the Colorado State Board of Medical Examiners, pursuant to C.R.S. 1973, 12-36-118(4)(c)(IV), as follows:

1. The Colorado State Board of Medical Examiners ("board") has jurisdiction over respondent and over the subject matter of these proceedings.

2. Respondent was licensed by the board to practice podiatry within the State of Colorado on January 14, 1964 and was so licensed at all times relevant hereto.

COUNT I

3. Complainant incorporates and realleges herein paragraphs 1 and 2 as though set forth in full in this paragraph 3.

4. On or before December 7, 1983, respondent formed a podiatrist-patient relationship with V. Mc., patient No. 1135, a male with a hammer toe condition on the second toe of his right foot.

5. On or about December 7, 1983, respondent was scheduled to perform a surgical procedure on the right foot of V. Mc. in the office of respondent. At the same time the medical records of respondent for this patient contained no clear indication as to which toe of V. Mc. was to be operated upon, mention being made in different parts of the medical records of the second, third, fourth and fifth toes, each mentioned as being in the hammered condition necessitating surgery.

6. On or about December 7, 1983, patient V. Mc. was in the offices of respondent, was prepared for surgery and surgical drapes were in place on his right foot. Prior to that time, no preoperative radiographs (x-rays) of the right foot of V. Mc. were taken by respondent or available to respondent. Before proceeding with the surgery from this point, radiographs of the right foot of V. Mc. were obtained by respondent.

7. On or about December 7, 1983, and in the course of performing his preparations for and surgery on patient V. Mc., respondent engaged in multiple acts contrary to sterile techniques, including his scrubbing, gowning and gloving for surgery while wearing a ring. Other examples

of sterile technique failure on that date by respondent included brushing sterile apparel of respondent against nonsterile areas of the room where the operation was occurring and the contamination by respondent of a sterile field with nonsterile equipment or articles.

8. On or before December 7, 1983, the medical records of respondent for patient V. Mc. contained inconsistent indications that V. Mc. suffered medical problems, took medications and underwent prior surgery. Prior hospitalizations were required for V. Mc., as disclosed by V. Mc. to respondent but not noted in the medical record for V. Mc. created by respondent on or before December 7, 1983. V. Mc. was also taking a diuretic medication on or about December 7, 1983, a fact not noted in the medical record for V. Mc. created by respondent on or before that date.

9. The care and treatment rendered to V. Mc. by respondent as described in paragraphs 3 through 8 above, separately, together, or both, constitutes one or more act or omission of grossly negligent conduct of the practice of podiatry or two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973 12-32-107(3)(i), as amended in 1983. In addition or in the alternative, when considered in conjunction with the facts alleged in counts two through six below, the acts alleged in this count I constitute one or more act or omission of grossly negligent conduct of the practice of podiatry or two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983.

COUNT II

10. Complainant incorporates and realleges herein paragraphs one through nine above as though set forth in full in this paragraph ten.

11. On or before November 23, 1983, respondent formed a podiatrist-patient relationship with R. W., patient NO. 1132, an elderly male with a chief complaint of a corn on the tip of his third toe, right foot, secondary to a hammer toe.

12. On or about November 23, 1983, respondent was scheduled to perform a surgical procedure on the right foot of R. W. in the office of respondent. At the same time, the medical records of respondent for R. W. included an informed consent form containing a description of the hammer toe correction procedure and the signature of R. W. The name, date, time, associated risks or complications, and witness portions of the informed consent form were not completed and were blank.

13. On or about November 23, 1983, respondent performed a surgical procedure to correct the hammer toe deformity on the third toe of the right foot of R. W. Thereafter, respondent proceeded to perform a secondary surgical procedure on the third toe of the right foot of R. W. removing a portion of the distal phalanx, which removal was unnecessary due to the initial surgical procedure performed on this toe.

14. In the course of performing the surgical procedure described in paragraph thirteen above, respondent was responsible for multiple breaks in sterile technique, including the brushing of sterile apparel of respondent

against nonsterile areas surrounding the operating field and contamination by respondent of the operating field with nonsterile equipment or articles.

15. After concluding the surgical procedures described in paragraph thirteen above, on November 23, 1983, the medical records of respondent for R. W. did not contain any mention of the secondary surgical procedure described in paragraph thirteen above and performed by respondent.

16. The care and treatment rendered to R. W. by respondent as described in paragraphs ten through fifteen above, separately, together or both, constitutes one or more act or omission of grossly negligent conduct of the practice of podiatry or consists of two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983. In addition or in the alternative, when considered in conjunction with the facts alleged in counts three through six below, and count one above, the acts alleged in this count two constitute one or more act or omission of grossly negligent conduct of the practice of podiatry or two or acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983.

COUNT III

17. Complainant incorporates and realleges herein paragraphs one through sixteen above as though set forth in full in this paragraph seventeen.

18. On or before November 23, 1983, respondent formed a podiatrist-patient relationship with R. B., patient

No. 1120, an older female scheduled to undergo foot surgery on November 23, 1983, in the office of respondent.

19. On or about November 23, 1983, the medical records of respondent for R. B. included a preoperative informed consent to surgery form that did not include a date, time, name, description of associated risks and complications, or the name of a witness.

20. On or about November 23, 1983, the respondent performed a surgical procedure to correct a hammertoe condition on the fourt and fifth toes of the right foot of R. B. using at least one piece of equipment that was not introduced into the operative field in an appropriate fashion and thereby caused a break in the sterile technique of respondent.

21. The care and treatment rendered to R. B. by respondent as described in paragraphs 17 through 20 above, separately, together or both, constitutes one or more act or omission of grossly negligent conduct of the practice of podiatry or consists of two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107 (3)(i), as amended in 1983. In addition or in the alternative, when considered in conjunction with the facts alleged in counts four through six below, as well as counts one and two above, the acts alleged in this count three constitute one or more act or omission of grossly negligent conduct of the practice of podiatry or two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983.

COUNT IV

22. Complainant incorporates and realleges here in paragraphs one through twenty-one above as though set forth in full in this paragraph twenty-two.

23. Prior to November 23, 1983, respondent formed a podiatrist-patient relationship with M. B., patient No. 1049, a male upon whom foot surgery was performed by respondent prior to November 23, 1983.

24. On or about November 23, 1983, the medical records of respondent for M. B. contained no indication that M. B. suffered from infection while noting that a culture was taken from the surgical site on that date.

25. On or about November 23, 1983, visual observation of the feet of M. B. revealed classical signs of post-operative infection at the site of a surgical wound including purulent exudate, edema, erythema and extending cellulitis.

26. On or about November 23, 1983, respondent obtained a culture specimen from the surgical wound on the foot of M. B. utilizing improper technique, including the use of an unsterile swab, contamination of the swab, placement of the speciment on an improper testing media and the failure to incubate the testing media and specimen in a timely fashion. In addition, other appropriate laboratory studies associated with infection investigations were not undertaken by respondent on November 23, 1983.

27. On or about November 23, 1983, respondent increased the antibiotic dosage being prescribed by respondent to M. B. beyond the recommended dosage levels for

that antibiotic, Cefadroxil, when used for the purposes prescribed by respondent here.

28. On or about November 23, 1983, the medical records prepared by or for respondent for M. B. contain no reference to the renal status of M. B., no reference to the potential allergies of M. B., and no reference to the antibiotic or dosage prescribed by respondent. Up to and including December 7, 1983, the medical records prepared by or for respondent for M. B. contained no reference to the culture taken November 23, 1983 or the results thereof.

29. The care and treatment rendered to M. B. by respondent as described in paragraphs twenty-two through twenty-eight above, separately, together or both, constitutes one or more act or omission of grossly negligent conduct of the practice of podiatry or consists of two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3) (i), as amended in 1983. In addition or in the alternative, when considered in conjunction with the facts alleged in counts five and six below, as well as counts one through three above, the acts alleged in this count four constitute one or more act or omission of grossly negligent conduct of the practice of podiatry or two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983.

COUNT V

30. Complainant incorporates and realleges herein paragraphs one through twenty-nine above as though set forth in full in this paragraph thirty.

31. On or before November 16, 1983, respondent formed a podiatrist-patient relationship with H. R., patient NO. 1088, a younger female.

32. On or about November 16, 1983, H. R. was present in the office of respondent and was requested to fill out her own surgical consent form, which she did. In addition, H. R. presented to respondent on or before that date standard weight-bearing radiographs of her feet taken by a different podiatrist and indicating a normal first metatarsal and proximal phalanx on her right foot.

33. On or about November 16, 1983, respondent performed "corrective" surgical procedures in his office on the first metatarsal and proximal phalanx on the right foot of H. R.

34. On or about November 16, 1983, respondent, in his office, performed an "excision of neuroma" between the third and fourth toes on the right foot of H. R., in a location and at a depth of surgical site that was inconsistent with the usual anatomical location of neuromas. Immediately following this procedure, H. R. continued to experience symptoms and without obtaining written informed consent, respondent proceeded to perform an osteotomy procedure on the fourth metatarsal of the right foot of H. R.

35. At the conclusion of the procedures described in paragraphs thirty-three and thirty-four above, respondent used a hypodermic needle to introduce local anesthesia into the surgical sites on the right foot of H. R. and, in order to obtain additional anesthesia for H. R., thereafter reinserted the same hypodermic needle into a multi-dose

vial of local anesthesia, thereby contaminating said vial and the contents of same.

36. On or about November 16, 1983, the medical records of respondent for H. R. contained an inaccurate representation of the implications and procedures existing and performed by respondent that date.

37. The care and treatment rendered to H. R. by respondent as described in paragraphs thirty through thirty-six above, separately, together or both, constitutes one or more act or omission of grossly negligent conduct of the practice of podiatry or consists of two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983. In addition or in the alternative, when considered in conjunction with the facts alleged in count six below, as well as counts one through four above, the acts alleged in this count five constitute one or more act or omission of grossly negligent conduct of the practice of podiatry or two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983.

COUNT VI

38. Complainant incorporates and realleges herein paragraphs one through thirty-seven above as though set forth in full in this paragraph thirty-eight.

39. On or before November 23, 1983, respondent formed a podiatrist-patient relationship with R. O., patient No. 1018, a middle-aged female.

40. On or about November 23, 1983, respondent performed a surgical procedure on the right foot of R. O., including a medial plantar fascia release, hammertoe corrections on the second and third toes, a hemiphalangectomy on the distal second toe and a osteotomy on the second metatarsal. During these procedures, multiple failures in the sterile technique of respondent occurred, including the brushing of sterile apparel of respondent against nonsterile areas surrounding the operating field and contamination of the operating field with nonsterile articles of equipment by respondent.

41. At the conclusion of the surgical procedure performed by respondent on R. O., respondent used a hypodermic needle to introduce local anesthesia into the surgical site on the foot of R. O. and, in order to obtain additional anesthesia for R. O., thereafter respondent reinserted the same hypodermic needle into a multi- dose vial of local anesthesia, thereby contaminating said vial and the contents of same.

42. On or about November 23, 1983, the medical records prepared by respondent for R. O. contained no indication that R. O. suffered from cardiovascular disease, past myocardial infarctions, past hospitalizations or took present medications. R. O. in fact possessed a significant past history of cardiovascular disease unreflected in the medical record on her prepared by respondent on November 23, 1983.

43. The care and treatment rendered to H. R. (sic) by respondent as described in paragraphs thirty-eight through forty-two above, separately, together or both, constitutes one or more act or omission of grossly negligent conduct

of the practice of podiatry or consists of two or more acts or omissions that fail to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983. In addition or in the alternative, when considered in conjunction with the facts alleged in counts one through five above, the acts alleged in this count six constitute one or more act or omission of grossly negligent conduct of the practice of podiatry or two or acts or omissions that failed to meet generally accepted standards of the practice of podiatry, in violation of C.R.S. 1973, 12-32-107(3)(i), as amended in 1983.

Dated this 21st day of December, 1983.

FOR THE ATTORNTY GENERAL

/s/ Thomas J. Lyons, 8381
Assistant Attorney General
Regulatory Law Section

Attorneys for Complainant

1525 Sherman Street, 3d Floor
Denver, Colorado 80203
Telephone: 866-3611

BEFORE THE STATE BOARD
OF MEDICAL EXAMINERS

STATE OF COLORADO

Proceeding No. RG ME DAAED

ORDER OF SUMMARY SUSPENSION
IN THE MATTER OF DISCIPLINARY PROCEEDINGS REGARDING THE LICENSE TO PRACTICE PODIATRY OF LENORD S. HORWITZ, C.P.M.,

Respondent.

TO: Lenord S. Horwitz, D.P.M.
5110 W. 38th Avenue
Denver, Colorado 80212

THIS MATTER having come before Inquiry Panel A of the Colorado State Board of Medical Examiners ("panel"), and the panel having reviewed its entire file in this matter and being otherwise fully advised in the premises, DOES FIND AS FOLLOWS:

1. Respondent was licensed by the Board of Medical Examiners of the State of Colorado("board"), to practice podiatry within the State of Colorado on January 14, 1964 and was so licensed at all times relevant hereto.

2. The panel, by virtue of respondent's licensure, has jurisdiction over respondent and over the subject matter of this action.

3. Reasonable grounds exist to believe that respondent has engaged in unprofessional conduct in violation of the Podiatry Practice Act, specifically C.R.S. 1973, 12-32-107(3)(i), as amended in 1983, ("an act or omission constituting grossly negligent conduct of the practice of podiatry or two or more acts or omissions which fail to meet generally accepted standards of the practice of podiatry."

4. The panel received a report containing the following:

a. On or before December 7, 1983, respondent formed a podiatrist-patient relationship with V. Mc., patient No. 1135, a male with a hammer toe condition on the second toe of his right foot.

b. On or about December 7, 1983, respondent was scheduled to perform a surgical procedure on the right foot

of V. Mc. in the office of respondent. At the same time the medical records of respondent for this patient contained no clear indication as to which toe of V. Mc. was to be operated upon, mention being made in different parts of the medical records of the second, third, fourth and fifth toes, each mentioned as being in the hammered condition necessitating surgery.

c. On or about December 7, 1983, patient, V. Mc. was in the offices of respondent, was prepared for surgery and surgical drapes were in place on his right foot. Prior to that time, no preoperative radiographs (x-rays) of the right foot of V. Mc. were taken by respondent or available to respondent. Before proceeding with the surgery from this point, radiographs of the right foot of V. Mc. were obtained by respondent.

d. On or about December 7, 1983, in the course of performing his preparations for and surgery on patient V. Mc., respondent engaged in multiple acts contrary to sterile techniques, including his scrubbing, gowning and gloving for surgery while wearing a ring. Other examples of sterile technique failures on that date by respondent included brushing sterile apparel of respondent against nonsterile areas of the room where the operation was occurring and the contamination by respondent of the sterile field with nonsterile equipment and articles.

e. On or before December 7, 1983, the medical records of respondent for patient V. Mc. contained inconsistent indications that V. Mc. suffered medical problems, took medications or underwent prior surgery. Prior hospitalizations were required for V. Mc. as disclosed by V. Mc. to respondent but not noted in the medical record for V. Mc. created

by respondent on or before December 7, 1983. V. Mc. was also taking a diuretic medication on or about December 7, 1983, a fact not noted in the medical record for V. Mc. created by respondent on or before that date.

f. On or before November 23, 1983, respondent formed a podiatrist-patient relationship with R. W., patient No. 1132, an elderly male with a chief complaint of a corn on the tip of his third toe, right foot, secondary to a hammer toe.

g. On or about November 23, 1983, respondent was scheduled to perform a surgical procedure on the right foot of R. W. in the office of respondent. At the same time, the medical records of respondent for R. W. included an informed consent form containing a description of the hammer toe correction procedure and the signature of R. W. The name, date, time, associated risks or complications, and witness portions of the informed consent form were not completed and were blank.

h. On or about November 23, 1983, respondent performed a surgical procedure to correct the hammer toe deformity on the third toe of the right foot of R.W. Thereafter, respondent proceeded to perform a secondary surgical procedure on the third toe of the right foot of R. W. removing a portion of the distal phalanx, which removal was unnecessary due to the initial surgical procedure performed on this toe.

i. In the course of performing the surgical procedure described in paragraph h above, respondent was responsible for multiple breaks in sterile technique, including the brushing of sterile apparel of respondent against nonsterile areas surrounding the operating field and contamination of the operating field by respondent with nonsterile equipment or articles.

j. After concluding the surgical procedures described in paragraph h above, on November 23, 1983, the medical records prepared by respondent for R.W. did not contain any mention of the secondary surgical procedure described in paragraph h above and performed by respondent.

k. On or before November 23, 1983, respondent formed a podiatrist-patient relationship with R. B., patient No. 1120, an older female scheduled to undergo foot surgery on November 23, 1983, in the office of respondent.

l. On or about November 23, 1983, the medical records of respondent for R. B. included a preoperative informed consent to surgery form that did not include a date, time, name, description of associated risks and complications, or the name of a witness.

m. On or about November 23, 1983, the respondent performed a surgical procedure to correct a hammertoe on the fourth and fifth toes of the right foot of R.B., using at least one piece of equipment that was not introduced into the operative field in an appropriate fashion and thereby caused a break in the sterile technique of respondent.

n. Prior to November 23, 1983, respondent formed a podiatrist-patient relationship with M. B., patient No. 1049, a male upon whom foot surgery was performed by respondent prior to November 23, 1983.

o. On or about November 23, 1983, the medical records of respondent for M. B. contained no indication that M. B. suffered from infection, while noting that a culture was taken from the surgical site on that date.

p. On or about November 23, 1983, visual observation of the feet of M. B. revealed classical signs of post-oper-

ative infection at the site of a surgical wound, including purulent exudate, edema, erythema and extending cellulitis.

q. On on about November 23, 1983, respondent obtained a culture specimen from the surgical wound on the foot of M. B. utilizing improper technique, including the use of an unsterile swab, contamination of the swab, placement of the specimen on an improper testing media and the failure to incubate the testing media and specimen in a timely fashion. In addition, other appropriate laboratory studies associated with infection investigations were not done by respondent on November 23, 1983.

r. On or about November 23, 1983, respondent increased the antibiotic dosage being prescribed by respondent to M. B. beyond the recommended dosage levels for that antibiotic, Cefadroxil, when used for the purposes prescribed by respondent here.

s. On or about November 23, 1983, the medical records prepared by or for respondent for M. B. contain no reference to the renal status of M. B., no reference to the potential allergies of M. B., and no reference to the antibiotic or dosage prescribed by respondent. Up to and including December 7, 1983, the medical records prepared by or for respondent for M. B. contained no reference to the culture taken November 23, 1983 or the results thereof.

t. On or before November 16, 1983, respondent formed a podiatrist-patient relationship with H. R., patient No. 1088, a younger female.

u. On or about November 16, 1983, H. R. was present in the office of respondent and was requested to fill out her own surgical consent form, which she did. In addition, H. R.

presented to respondent on or before that date standard weight bearing radiographs of her feet taken by a different podiatrist and indicating a normal first metatarsal and proximal phalanx on her right foot.

v. On or about November 16, 1983, respondent, in his office, performed "corrective" surgical procedures on the first metatarsal and proximal phalanx on the right foot of H. R.

w. On or about November 16, 1983, respondent, in his office, performed an "excision of neuroma" between the third and fourth toes on the right foot of H. R., in a location and at a depth of surgical site that was inconsistent with the normal anatomical location of neuromas. Immediately following this procedure, H. R. continued to experience symptoms and without obtaining written informed consent, respondent proceeded to perform an osteotomy procedure on the fourth metatarsal of the right foot of H. R.

x. At the conclusion of the procedures described in paragraphs v and w above, respondent used a hypodermic needle to introduce local anesthesia into the surgical sites on the right foot of H. R. and, in order to obtain additional anesthesia for H. R., thereafter reinserted the same hypodermic needle into a multi-dose vial of local anesthesia, thereby contaminating said vial and the contents of same.

y. On or about November 16, 1983, the medical records of respondent for H. R. contained an inaccurate representation of the indications and procedures existing and performed by respondent that date.

z. On or before November 23, 1983, respondent formed a podiatrist-patient relationship with R. O., patient No. 1018, a middle-aged female.

aa. On or about November 23, 1983, respondent performed surgical procedures on the right foot of R. O., including a medial plantar fascia release, hammertoe corrections on the second and third toes, a hemiphalangectomy on the distal second toe and a ostestomy of the second metatarsal. During this procedure, multiple failures in the sterile technique of respondent occurred, including the brushing of sterile apparel of respondent against nonsterile areas surrounding the operating field and contamination by respondent of the operating field with nonsterile articles or equipment.

bb. At the conclusion of the surgical procedure performed by respondent on R. O., respondent used a hypodermic needle to introduce local anesthesia into the surgical site on the foot of R. O. and, in order to obtain additional anesthesia for R. O., thereafter respondent reinserted the same hypodermic needle into a multi-dose vial of local anesthesia, thereby contaminating said vial and the contents of same.

cc. On or about November 23, 1983, the medical records prepared by respondent for R. O. contained no indication that R. O. suffered from cardiovascular disease, past myocardial infarction, past hospitalizations or look present medications. R. O. in fact possessed a significant past history of cardiovascular disease unreflected in the medical record on her prepared by respondent on November 23, 1983.

5. The panel specifically finds that it has reasonable grounds to believe that respondent's demonstrated lack of podiatric knowledge as set forth in paragraph 4 above constitutes such a threat to any present and future patients of

respondent, and thus to the public health, safety and welfare, as to imperatively require emergency action, to wit, the summary suspension of respondent's medical license pending disciplinary proceedings as authorized by C.R.S. 1973, 24-4-104(4).

THEREFORE, IT IS HEREBY ORDERED that the license of Lenord S. Horwitz, D.P.M. to practice podiatry in the State of Colorado be and hereby is summarily suspended pending a final determination of whether respondent's license to practice podiatry in the State of Colorado should be suspended or revoked pursuant to the provisions of C.R.S. 1973, 12-32-107, as amended in 1983;

And pending the outcome of said proceedings, IT IS HEREBY FURTHER ORDERED that Lenord S. Horwitz, D.P.M. cease, desist and refrain from any further acts for which a license to practice podiatry is required by the laws of the State of Colorado.

DATED this 21st day of December, 1983.

COLORADO STATE BOARD OF
MEDICAL EXAMINERS
(Inquiry Panel A)

/s/ ROBERT L. LEDERER, M.D.

APPENDIX G

BEFORE THE STATE BOARD
OF MEDICAL EXAMINERS

STATE OF COLORADO

Proceeding No. RG ME DAAED

INITIAL DECISION

PEOPLE OF THE STATE OF COLORADO *ex rel.*
DUANE WOODARD, ATTORNEY GENERAL,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

Hearing was held in this matter on January 19, 20, 23, 24 and 25, 1984 before Marshall A. Snider, hearing officer, Department of Administration, Division of Hearing Officers. Complainant was represented by Thomas J. Lyons and William Higgins, Assistant Attorneys General. Respondent was present at the hearing and was represented by Jordan Hochstadt and Richard S. Strauss. Pursuant to C.R.S. 24-4-105 (14) the hearing officer renders the following Initial Decision.

FINDINGS OF FACT

1. Respondent was licensed by the Colorado State Board of Medical Examiners ("the Board") to practice podiatry on January 14, 1964 and has been so licensed at all time relevant to these proceedings.

2. On July 15, 1984 Respondent and the Board entered into a Stipulation in order to settle certain pending discipli-

nary matters. The Stipulation provided for Respondent to be supervised by an independent ambulatory foot surgeon for a period of six months from September 1, 1984. The areas of supervision were Respondent's record keeping and surgical practices. Stephen F. Albert, D.P.M. ("Albert") was selected as the supervising podiatrist and served in this capacity until December 12, 1983.

3. On December 21, 1983 the Board summarily suspended Respondent's license to practice podiatry. The summary suspension was based on the same facts which form the basis for the charges in the instant case.

4. Respondent practices percutaneous and minimal incision surgery. Percutaneous surgery involves the making of a very small incision — a puncture — to perform the surgery. Minimal incision surgery involves the making of a slightly larger, but nonetheless small, incision. These types of foot surgery are distinguishable from what is known as "traditional" foot surgery. In traditional surgery, usually performed in hospitals under hospital protocol, large incisions are made to expose tissues, ligament and bones. Percutaneous and minimal incision surgery, by reducing the damage to underlying tissue, generally result in less convalescence than traditional surgery. While many practitioners around the country perform percutaneous and minimal incision surgery, these surgeries are not performed by a large number of podiatrists in Colorado. Many podiatrists disagree with the concept of percutaneous or minimal incision surgery.

5. Generally accepted standards of the practice of podiatry (referred to in this decision as "the standard of care") are national in scope. The same standards apply in Colorado as apply in the rest of the country.

6. The sterile field (the area in and around the surgery in which strict standards of sterility must be observed) differs in the different types of surgery discussed above. In traditional surgery the sterile field consists of the foot and an area defined by a 12 inch radius around the foot. In minimal incision surgery the sterile field consists of the foot and anything it touches. In percutaneous surgery the sterile field is the incision and anything that goes into it. Podiatrists have a difference of opinion on this subject and many podiatrists, including Albert, believe that the sterile field is that described for traditional surgery, regardless of the type of foot surgery being performed. Based upon all of the evidence, however, the hearing officer finds that the sterile field differs for each type of surgery, as described above.

7. Respondent used multi-dose vials of xylocaine, a local anesthetic, in his surgeries. On occasion Respondent would inject a patient with xylocaine and insert the same hypodermic needle used in that injection into a multi-dose vial, thus contaminating the vial and its contents. If the contents of the same vial were injected into another patient the contamination would be passed on to the other patient. If the vial were used on the original patient there would be no contamination: in essence, the original patient would be receiving his own germs back. There was no evidence that Respondent ever utilized a multi-dose vial of xylocaine to inject one patient and then used that same vial on a second patient. Once contaminated, such vials and their contents are capable of being re-sterilized.

8. Respondent generally dictated his patient records on tape and a secretary typed these records overnight. The records would be placed on Respondent's desk, usually the

next morning, and Respondent's practice was to dictate or interlineate any changes or corrections and return the records to the typist. On some occasions this correction process would be repeated after the second draft was reviewed.

9. On December 7, 1983 Albert removed copies of certain patient records from Respondent's office to assist in preparing his report to the Board. Albert was aware that some of these records were incomplete and might be modified before becoming part of the final patient records.

10. On December 7, 1983 Respondent's typist did not finish all of the charts presented to her since Respondent was to be leaving on a vacation December 21 and the typist planned to catch up on the typing during that period.

11. On November 23, 1983 Respondent performed surgery on patient R.B. During the course of the surgery the drill used by Respondent broke. Respondent's assistant brought Respondent a new drill and cord which had been sterilized and wrapped in an outer cloth and two inner cloth packs that were sterilized with the drill and the cord. The assistant's hands were not gloved when she brought in this cord and drill.

12. Prior to surgery on R.B. Respondent discussed with R.B. the nature of the surgery and possible risks and complications resulting from the surgery. R.B. understood the matters explained to her. R.B. signed a written Informed Consent to Surgery form which described the procedure to be performed but did not set forth the date and time, patient's name, signature of a witness or a specification of possible risks and complications.

13. On November 16, 1983 Respondent performed surgery on patient M.B. Patient M.B. has no problem with his

kidneys and never mentioned any such problem to Respondent. M.B.'s Patient History, prepared prior to the date of surgery and signed by M.B., indicates that M.B. has no kidney disease. No evidence was presented by Complainant regarding the potential allergies of M.B. alleged in the Formal Charges.

14. On November 23, 1983 M.B. presented himself to Respondent with signs of infection at the site of his surgery. Respondent increased M.B.'s prescription for cefadroxil, an antibiotic, from one gram (1000 mg.) to 1500 mg. per day. M.B. never took the increased dosage. Many practitioners will not prescribe more than 1000 mg. of cefadroxil daily, although some practitioners choose to treat infections aggressively and will prescribe in excess of 1500 mg. of that drug daily.

15. On November 23, Respondent took a culture from the exudate (the material excreted by the wound) in the site of the suspected infection on M.B.'s foot. The testimony regarding this procedure was conflicting. Considering all of the evidence the hearing officer finds that the swabs used to take the culture were kept in a sack and that the sack and swabs were sterilized one or two times per week. The sack and swabs were kept in a container that Albert did not believe could be sterilized. Respondent's assistant testified that the container was in fact sterilized once or twice a week. There was no direct evidence that the swabs were not sterile and the hearing officer finds that the swabs were, in fact, sterile.

16. There was also a conflict in the evidence as to whether Respondent dragged the swab across M.B.'s foot before taking the culture, thus contaminating the swab. It was possible that a germicide used in dressing the wound

would kill any germs on the swab even if the swab did contact the foot. If the swab touched either the foot or the germicide the culture results would be invalid. Albert apparently did not mention to Respondent that the swab may have been contaminated, and he could be expected to do so since Respondent could easily have used a new swab. Considering all of the evidence the hearing officer concludes that Complainant has not proved by a preponderence of the evidence that the swab was contaminated by being brought into contact with M.B.'s foot.

17. Once the culture was taken from M.B.'s wound the culture plate upon which it was placed remained exposed to the air for one to three hours before being incubated. Some bacteria will live as long as six hours before being incubated, but the longer the plate sits before incubation the more chance that organisms will die and invalidate the results of the culture. Respondent made no specific effort to have the culture plate placed in an incubator. The plate merely sat on a counter until Respondent's assistant noticed it and placed it in an incubator.

18. There was no evidence regarding the allegations of the Formal Charges that the culture medium was improper or that appropriate laboratory studies were not undertaken.

19. M.B.'s patient records copied by Albert on December 7 make no reference to the culture or the increase in the amount of cefadroxil prescribed for M.B. Respondent's final records include such references.

20. On December 2, 1983 Respondent performed surgery on the second toe of the right foot of patient V. Mc. Patient records of V. Mc. copied by Albert on December 7

made reference to the affected toe as the third, fourth and fifth toe in various places but all of these references were struck over to indicate the second toe. One of these changes was made on the patient's Informed Consent to Surgery form and pointed out to the patient. Other incorrect references were in Respondent's dictated notes. The final version of the patient records reference the correct toe.

21. Prior to the commencement of surgery on V. Mc. there were no available x-rays. The patient was prepared for surgery and surgery was about to commence when Albert pointed out the absence of x-rays to Respondent. X-rays were then taken. While Respondent denies that he was about to start surgery without x-rays, he has no independent recollection in this regard and his denial was based upon statements made to him by his assistant, who did not testify on this point.

22. In all surgeries observed by Albert Respondent scrubbed while wearing a plain gold wedding band and wore the ring under sterile gloves. The ring did not touch the patient or any surgical instrument and did not puncture the glove. The ring did not cause a breach of sterility. Although Albert saw Respondent wear this ring in each surgery he reported it only in connection with the surgery on V. Mc.

23. Albert testified that in the surgery on V. Mc. Respondent came in contact with non-sterile objects (the back of a television set used to distract and entertain patients undergoing surgery and the edge of an adjacent tray). There was no evidence as to what part of Respondent's body or clothing touched these objects or whether the part of Respondent's body or clothing touching the ob-

jects entered the sterile field for percutaneous or minimal incision surgery.

24. Respondent's initial notes on patient V. Mc. contained no mention of prior surgeries of V. Mc. These prior surgeries are listed on the Patient History signed by V. Mc. on November 18. The Patient History also reflects that V. Mc. does not suffer from gout or hypertension and is not taking medications. V. Mc. signed this form and there is no evidence that V. Mc ever told Respondent about these matters or that Respondent failed to inquire about them.

25. On November 23, 1983 Respondent performed surgery on patient R.O. Respondent has know (sic) R.O. for over fifteen years, and was familiar with the facts that R.O. had suffered a heart attack and was taking medication for a heart condition. The most recent records for R.O. do not contain this information although records prepared in 1982 do so. The Patient History filled out by R.O. in August, 1983 reflects her heart condition.

26. There was a conflict in the testimony of Albert and Dr. Robert Timm, who also observed the surgery on R.O., as to whether the sleeve of Respondent's gown touched the television set or its stand, thus rendering the gown unsterile. The testimony also differed as to whether the cord of the drill used in this surgery touched non-sterile objects. Because Respondent would have had to reach up and out over three feet to touch his sleeve on the television or its stand, a physically difficult action, and because Dr. Timm did not observe this happening, the hearing officer concludes that it has not been proven that the gown was contaminated in this fashion. In any case, Albert apparently never pointed out this alleged contamination of the

gown to Respondent: the problem could have been easily remedied by a change of gowns. There was no evidence that the cord of the drill or the sleeve of the gown entered the sterile field.

27. On November 16, 1983 Respondent performed foot surgery on patient H.R. Respondent removed a bunion (an enlarged portion of bone) from the large toe on the right foot of H.R. H.R. also had a condition on the large toe of her right foot known as a Hallux Valgus condition. In this condition the toe has an "L" shape and the end of the toe points toward the other toes. The Hallux Valgus condition was a mild one, but there was a conflict in the testimony as to whether the affected toe was so far out of acceptable limits for this condition that surgery was necessary. Albert testified that the toe was in the acceptable range (0-8 degrees out of line) while Respondent testified that the normal range is 0-5 degrees and that H.R.'s toe was 10-12 degrees out of line. An x-ray that may have clarified the extent of the condition was not available at the hearing, through no fault of either party. Respondent straightened this toe by cutting the bone, a procedure known as an osteotomy. Albert never disagreed with Respondent's performing the osteotomy until after the fact.

28. H.R. also complained of a burning sensation between the third and fourth toes on her right foot. This symptom is consistent with two possible conditions: a neuroma (the enlargement of or a growth on a nerve) and a nerve compression (a nerve which is being impinged or squeezed). The treatment of choice for a neuroma is to excise the neuroma and Albert agreed with this diagnosis

and the performance of an excision. The breaking of the bone to relieve pressure on the nerve (an osteotomy) is an accepted procedure for treating a nerve compression.

29. Respondent made an incision for the purpose of excising a neuroma and found no neuroma. Albert testified that the incision was not sufficiently deep and that Respondent appeared, therefore, not to know the location of a neuroma. Albert suggested to Respondent that he cut deeper but Respondent stated that he had performed the procedure in the correct manner. The hearing officer finds that there was insufficient proof that Respondent failed to perform this procedure in the correct manner by failing to make a sufficiently deep incision. First, Respondent performed the surgery while Albert only observed. Second, excision of neuroma is a well known technique which Respondent has performed hundreds of times. While the Board has charged Respondent with performing unnecessary surgery, with record keeping violations and with breaks in sterile technique, this is the only charge that he is substandard in his surgical technique. It is not credible that a practitioner with Respondent's years of experience, whose surgical technique appears adequate, would not know the location of a suspected neuroma. After hearing the evidence even the hearing officer knows the approximate depth at which a neuroma might be located and it is unlikely that Respondent would, while being observed by a Board appointed supervisor, make as gross an error as to make only the superficial incision claimed by Albert.

30. After the above procedure failed to reveal a neuroma in Respondent's opinion, H.R. complained that the burning sensation she had complained of still existed. Re-

spondent then discussed with H.R. the performance of an osteotomy on her fourth toe, since Respondent now thought that the problem was an impingement. Respondent explained this additional surgery and the risks associated with it to H.R. Although H.R. had been administered nitrous oxide and was quite apprehensive throughout the surgery, she was fully awake, rational and coherent at this time, and fully understood the situation. H.R. gave Respondent her informed, knowing consent to perform the osteotomy on her fourth toe. H.R.'s current condition in this regard is very good and the surgery has served its purpose of relieving her pain.

31. On November 23, 1983 Respondent performed surgery on patient R.W., an 84 year old male, to correct a hammertoe condition. The written Informed Consent to Surgery form signed by R.W. listed only the procedure to be performed when R.W. signed it. The date, time, patient's name and the section of the form on risks and complications were not filled in when the form was signed. Respondent did explain to R.W., prior to the surgery, the procedure and associated risks and complications.

32. After surgically correcting the hammertoe condition, Respondent removed an exostosis (a growth of calcium or bone) from the end of the third toe of R.W.'s right foot. The exostocis was of long standing duration.

33. Albert testified that the sleeve of Respondent's gown and the cord of the power drill touched non-sterile objects such as the television stand, x-ray stand and the patient's adjacent foot. Dr. Timm did not observe the cord touching anything non-sterile. For this reason, and the reasons set forth in paragraph 26 of these Findings of

Fact, the hearing officer finds no break in sterility in this regard. Albert acknowledges that Respondent was unaware of the alleged breaks in sterility, and a comment from Albert would presumably have rectified the situation and maintained sterility.

34. The records taken by Albert on December 7 regarding patient R.W. did not mention the exostosectomy. The permanent records for this patient do reference this procedure.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and his license to practice podiatry. Respondent moved to dismiss the charges on the grounds that the Board lacked jurisdiction. The basis of the motion was that the Board summarily suspended Respondent's license without complying with the investigatory procedures required by C.R.S. 12-36-118(4) (applicable to podiatrists under the provisions of C.R.S. 12-32-107(2)). The hearing officer denied this motion at the close of the evidence. The Administrative Procedure Act [C.R.S. 24-4-104(4)], as interpreted in *Colorado State Board of Medical Examiners v. District Court,* 191 Colo. 158, 551 P.2d 194 (1976), specifically permits the summary suspension of a license under the Medical Practice Act. In that decision the Court upheld a summary suspension even though such a suspension was accomplished without adhering to specific hearing procedures existing in the Medical Practice Act at the time of that decision. The court specifically rejected the physician's argument that the summary suspension provision of the Administrative Procedure Act did not apply in light of the provisions of the Medical Practice Act.

Respondent acknowledges that the Board must, in extreme cases, have the power to summarily suspend licenses to protect the public, even if Section 118 (4) is not complied with. Respondent argues, however, that this case is not sufficiently extreme. The hearing officer declines the invitation to engage in this type of line drawing. It is for the Board, not the hearing officer, to determine in its discretion if sufficient cause for a summary suspension exists. If, as Respondent acknowledges, a summary suspension may be issued in some cases without following Section 118(4), then a summary suspension may issue in all cases without following this procedure.

2. Respondent moved to dismiss the charges at the close of complainant's case. The hearing officer reserved ruling on that motion and now denies it.

3. Respondent did not deviate from the standard of care in reinserting needles in multi-dose vials of anesthetic (all references to the "standard of care" in these Conclusions of Law are references to the standard set forth in C.R.S. 12-32-107(3) (i). There was no evidence in this case concerning "grossly negligent conduct", and these Conclusions of Law thus are limited to whether Respondent failed to meet generally accepted standards of the practice of podiatry). It was undisputed that unless the anesthetic were injected into a subsequent patient there would be no harm, and re-using the vial on the same patient would not violate the standard of care. The better procedure appears to be to use a separate drawing needle to withdraw the drug and a second needle to inject patients. This procedure prevents the possibility of harm to a subsequent patient by a practitioner accidentally using a vial

that had not been re-sterilized. However, in this case no subsequent patient was injected. The standard of care does not require the best procedure possible in all cases. While this better procedure may be suggested to Respondent (which could have been done as part of the supervision), the hearing officer does not believe Respondent is subjcet to discipline for using a procedure that does not involve an unreasonable risk to patients and would only cause a risk to patients if Respondent were later negligent in his subsequent use of the vial. If, as Albert testified, reinsertion of the needle into the vial and then the same patient does not violate the standard of care, it cannot be said that the mere reinsertion of a needle in a multidose vial, by itself, violates the standard of care.

4. The use of written Informed Consent to Surgery forms is not mandated by the standard of care. While this may be the common practice, it bears no relationship to the care of the patient. What is required is that the patient be fully informed and this was done in all cases, although not in writing. The use of a written form serves more to protect the practitioner than the patient and is required by hospitals and malpractice carriers rather than by any standard of care. The improper completion of these forms may have been a good subject for the supervisory podiatrist to discuss with Respondent, but it does not violate the standard of care.

5. Respondent properly informed all of the patients at issue in this case regarding the procedures and their risks and complications. Thus, Respondent met the standard of care in regard to receiving informed consent.

6. The incorrect references to the toe of patient V. Mc. to be operated on were all contained in notes which were not final. There is insufficient evidence of a deviation from the standard of care in respect to these entries.

7. The failure of Respondent to have available x-rays of V. Mc. until he had virtually started the surgery is such a major oversight as to constitute a deviation from the standard of care.

8. There was insufficient evidence to meet the burden of proof that Respondent had acted contrary to sterile technique in the surgeries performed on V. Mc., R.O. and R.W. Even if the evidence were sufficient to show that Respondent or the drill cord had touched non-sterile objects, there was no evidence that the sterile field had been violated. In rendering an opinion that the sterile field had been violated Albert applied the definition of the sterile field applicable to traditional surgery, including the 12 inch radius around the foot. The hearing officer has found, however, that this sterile field is not applicable to minimal incision and percutaneous surgery.

9. It is not a deviation from the standard of care in percutaneous or minimal incision surgery for Respondent to wear a ring under sterile gloves. Albert's opinion is basically that to do so is not an accepted technique, but such a determination does not render the wearing of a ring to be a violation of a standard of care. There is no evidence that wearing the ring constitutes any unreasonable or unacceptable risk to a patient.

10. There was insufficient evidence to support the claim that Respondent deviated from the standard of care by improperly maintaining patient records regarding the

medical history of patient V. Mc. Albert testified that V. Mc. told Albert that V. Mc. suffered certain conditions and took certain medication. V. Mc.'s Patient History negatives these matters. There was absolutely no evidence that V. Mc. advised Respondent of these matters or that Respondent failed to make proper inquiry.

11. The exostosis on the toe of patient R.W. was of long-standing duration and the patient was elderly. While Albert was of the opinion that the exostosectomy was unnecessary, Dr. Timm testified that under these conditions such a procedure is an acceptable procedure which is often necessary, in addition to the hammertoe correction, to relieve pain. There was insufficient evidence from which the hearing officer can conclude that removal of the exostosis was unnecessary and therefore no deviation from the standard of care has been proven.

12. There was insufficient evidence to conclude that the preliminary records regarding surgery on R.W. were any more than a first draft. The failure of these records to reflect the exostosectomy procedure does not violate the standard of care.

13. There is no evidence that the second drill used in the surgery of R.B. became contaminated and no violation of the standard of care has been shown in this regard. While Respondent's assistant was not gloved, she never directly touched or contaminated the drill or cord.

14. With regard to the culture taken from the wound of patient M.B. the hearing officer has found that the swab was sterile and no violation exists on that point. However, Respondent did violate the standard of care by leav-

ing the culture plate to stand exposed to the air for a period of one to three hours without giving any instructions to his assistant to incubate the culture and without taking steps to do so himself. The very bacteria sought to be identified by this procedure could die as a result of this delay and Respondent gave little thought to expeditiously incubating the culture. Had his assistant not entered the room to clean it up when she did the plate may not have been incubated until even more time had passed. Such inattention to the need for prompt incubation violates the standard of care.

15. The failure of the initial records on M.B. to mention the culture or a change in prescription may have been no more than errors in a draft. The evidence was insufficient to support a claim that Respondent maintained inaccurate records.

16. There was no evidence that M.B. suffered from kidney disease and his Patient History reflects this fact. There was no deviation from the standard of care in maintaining medical records in this regard.

17. There was insufficient evidence that the increase in medication prescribed for M.B. deviated from the standard of care. While Albert testified that the amount prescribed was more than practitioners usually prescribe, Dr. Timm testified that some practitioners might prescribe even greater dosages. In any event, Albert's testimony was general and did not take into account the specific needs and condition of patient M.B.

18. There was insufficient evidence to conclude that the osteotomy procedure performed on patient H.R.'s large

toe was unnecessary. The evidence was insufficient to determine whether the Hallux Valgus condition was in or out of acceptable limits. Albert concluded that there was insufficient radiological evidence to perform this procedure, but the x-ray which may have possibly resolved this evidentiary conflict was not in evidence. Since Complainant had the burden of proof on this issue, as on all other factual issues, it cannot be concluded that Respondent deviated from the standard of care.

19. The hearing officer has found that the procedure to excise the neuroma in the surgery of H.R. was properly performed. Since that procedure was accomplished properly, the existence of continued pain in the patient's foot made it reasonable for Respondent to consider other causes, such as a nerve compression, for H.R.'s pain. The osteotomy performed is the accepted procedure for dealing with H.R.'s condition and no deviation from the standard of care was proven as to this procedure. H.R. gave a knowing and informed consent to this procedure and there is no requirement that this consent be in writing.

20. Respondent is charged with maintaining inaccurate records reflecting the x-rays that were in Respondent's office prior to the surgery on H.R. There is absolutely no support in the evidence for this charge.

21. Although Respondent's most current records for patient R.O. do not reflect her condition, her recent Patient History form does so. The hearing officer concludes that the standard of care requires Respondent to keep his records current in this regard since he cannot rely on his memory of the condition of every patient. Even though the Patient History completed by R.O. on August 30, 1983

reflects her heart condition, if R.O. had neglected to recall or adequately report her condition on that history, Respondent had no current records to reflect that fact. In the case of R.O. Respondent relied on both his memory and that of his patient to inform him or her condition. Fortunately, both memories served in this case. But the hearing officer concludes that this form of "record keeping" raises an unreasonable risk of harm to a patient and is below the standard of care.

RECOMMENDED ORDER

The violations of C.R.S. 12-32-107(3)(i) found in this case are relatively minor compared to the overall charges. Nevertheless, the violations found in paragraphs 8 and 15 are fairly serious deviations from the standard of care. Respondent's license has already been suspended for approximately seven weeks and such a suspension is more than sufficient discipline for the violations proven. Other areas of Respondent's practice, while not found to be substandard, could be improved. However, these improvements should be dealt with under the supervisory structure established by the Stipulation.

It is the recommendation of the hearing officer that Respondent's license be immediately reinstated, that no further discipline be imposed as a result of these charges, and that Respondent continue under supervision pursuant to the Stipulation.

/s/ Marshall A. Snider, Hearing Officer

DATED: In Denver, Colorado
February 6, 1984

APPENDIX H

BEFORE THE STATE BOARD
OF MEDICAL EXAMINERS
STATE OF COLORADO

Proceeding No. RG ME DAAED

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

PEOPLE OF THE STATE OF COLORADO *ex rel.* DUANE WOODARD, ATTORNEY GENERAL,

Complainant,

vs.

LENORD S. HORWITZ, D.P.M.,

Respondent.

Panel B of the Colorado State Board of Medical Examiners, having reviewed the transcripts of the hearing and the exhibits and the findings of fact and conclusions of law recommended by the hearing officer, FINDS AND CONCLUDES:

1. It has jurisdiction.

2. The Board affirms the findings of fact of the Initial Decision with the exception of:

> Finding #15—the Panel finds that the weight of evidence supports findings of fact that the procedure and technique used by Dr. Horwitz did not render such swabs sterile and constituted acts and omissions which failed to meet generally accepted standards of medical care.

3. The Panel affirms the conclusions of law with the following exceptions:

a. #14 is divided into 14(a) regarding the swab; and #14(b) regarding the incubation of the culture.

Regarding 14(a)—the Panel concludes that Dr. Horwitz' procedure and technique in the use of swabs does not insure that the swabs are sterile and single and is a violation of the standard of care.

b. The Panel specifically affirms the conclusion of law of #14(b) that Dr. Horwitz' inattention to the need for prompt incubation of a culture violates the standard of care.

c. Regarding #7—the Panel specifically affirms that the failure of Dr. Horwitz to have patient V.Mc's X-rays available until he had virtually started surgery is a major oversight constituting a deviation from the standard of care.

4. The temporary, emergency suspension of Dr. Horwitz' license to practice podiatry previously ordered by Panel A should be terminated.

5. Dr. Horwitz' substandard medical procedures referred to in this order and in the order of the hearing officer are a danger to the public.

6. Dr. Horwitz should be granted probation on the condition of supervision of his podiatric practice by one or more podiatrists approved by the Panel and on condition that Dr. Horwitz commit no acts or omission that constitute substandard medical care during the period of his probation.

7. Until such supervisory podiatrist or podiatrists are approved by the Panel Dr. Horwitz' license to practice podiatry should be suspended.

8. If no podiatrist approved by the Board can be recruited for the purpose of supervising Dr. Horwitz'

podiatric practice, Dr. Horwitz' license to practice podiatry should be suspended indefinitely.

NOW, THEREFORE, IT IS ORDERED:

1. That the summary suspension of Dr. Horwitz' license to practice podiatry previously ordered by Panel A be, and it hereby is, terminated.

2. That Dr. Horwitz be, and he hereby is, granted probation for period of one year on the conditions that during this period of time his practice of podiatry be supervised by one or more podiatrists approved by the Panel and that he commit no substandard acts or omissions in his podiatric practice during that period of time.

3. That until such supervising podiatrist or podiatrists be approved by the Panel, Dr. Horwitz' license to practice podiatry should be, and it hereby is, suspended, and his period of probation shall not begin until such supervising podiatrist or podiatrists are approved by the Panel.

4. That Dr. Horwitz shall submit to the panel the names of one to four podiatrists licensed in Colorado who are willing and able to supervise his podiatric practice.

5. That if Dr. Horwitz fails to submit any such names to the panel within 60 days from the date of this order or if the Board does not approve such supervising podiatrist or podiatrists, Dr. Horwitz' license to practice podiatry shall be suspended indefinitely.

6. That the panel shall by further order after the approval of the supervising podiatrist or podiatrists determine the methods and frequency of such supervision,

the periodicity and content of reports, and other administrative matters.

Dated this 1st day of May, 1984.

COLORADO STATE BOARD OF
MEDICAL EXAMINERS
(PANEL B)

By: John S. Carroll
Member

F. R. Pacquette
Member

Christine Peterson
Member

Stephen R. Kozloff
Member

COLORADO COURT OF APPEALS

No. 84CA0541

LENORD HORWITZ, D.P.M.,

Petitioner,

v.

COLORADO STATE BOARD OF MEDICAL EXAMINERS and THE PEOPLE OF THE STATE OF COLORADO, ex rel. DUANE WOODARD, Attorney General,

Respondents.

SUPPLEMENTAL ORDER OF HEARING PANEL B

THE STATE BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

THE STATE BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Proceeding No. RG ME DAAED

SUPPLEMENTAL ORDER OF HEARING PANEL B

PEOPLE OF THE STATE OF COLORADO ex rel.
DUANE WOODARD, Attorney General,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

Hearing Panel B hereby orders the following terms and conditions under which respondent could resume the practice of podiatry while serving a term of observed probation:

1. Hearings Panel B reaffirms the earlier findings of subject matter and personal jurisdiction over respondent.

2. Hearings Panel B reaffirms the earlier findings of statutory violations, in specific, three or more acts or omissions that violate the standard of care in the podiatric community.

3. Hearings Panel B finds that due to the substandard acts, or omissions found in the prior order of this panel, as well as in this order, respondent Horwitz should resume the practice of podiatry only in a observed environment and on probation for at least one year. The following terms and conditions shall apply to the observed probationary term imposed on respondent.

a. The podiatric practice of respondent shall be observed by podiatrists named on attached exhibit A.

b. The observers named shall be responsible for observing and reporting to this Hearings Panel regarding the following aspects of the podiatric practices of respondent; the taking and recording of patient histories; patient physical examinations; diagnosis and treatment of patients; taking and reading of radiographs; laboratory testing, including the obtaining the test specimens and the conduct of tests done intraoffice; operative technique; aseptic technique; use of medications on a post-operative basis; post-surgical follow-up care. The foregoing list is not and should not be considered to be all-inclusive. Instead it is intended to offer some guidance to the observers and to respondent respecting those aspects of the practice of respondent that may require particular scrutiny. The observers are hereby authorized to include in their observations and reports any additional data regarding the respondents practice that is deemed pertinent by the observers.

c. The observers appointed by this panel are required to visit the office(s) of respondent at least twice weekly for the first six months and once per week during the subsequent six months of the probationary period for the purpose of making their observations and reports. These visits shall include at least one visit per week scheduled to observe surgeries conducted by respondent. An observer may make unscheduled and unannounced visits. Respondent shall make all his podiatric records and all his activities involving the practice of podiatry available to the observers at any time requested by the observers. The observers shall spend a minimum of one hour observing during a visit with respondent.

d. The observers appointed by this panel shall have no obligation whatsoever to instruct, correct, inform, educate or direct respondent with respect to his practice of podiatry. The responsibility of the observers shall be to provide written reports with respect to observations made by the observers of the podiatric practice of respondent. Such written reports which indicate no substandard acts or omissions shall be submitted on a bimonthly basis to Hearings Panel B, Colorado State Board of Medical Examiners, 1525 Sherman Street, Denver, Colorado 80203. Any written report of the observers that is considered by the observers to indicate any substandard behavior or activity, shall be delivered by hand to the above address within forty-eight hours following such observation.

e. In any instance where the observers undertake to instruct, correct, inform, educate or direct respondent, with respect to the practice of podiatry, respondent shall undertake to conform his actions to the suggestions of the observers.

f. The podiatrists named on exhibit A, agree to act as observers on behalf of this panel and as such are agents of the Board of Medical Examiners. By such participation, they are entitled to the immunity protection of 12-36-118(3), C.R.S. (1983 Supp.).

g. Respondent shall be responsible for reimbursing the observers for their costs and time spent observing and writing reports to the panel. The observers shall charge no more than $125 per hour for their time. Respondent shall reimburse observers on a weekly basis.

h. At all times while on probation, respondent shall be covered by podiatric liability insurance in the amount of $100,000.

Proof that such coverage exists and access to the responsible agent for the insurance carrier shall be made available by respondent to his observers on demand.

i. During the term of probation, respondent shall make available copies of any records requested by his observers.

4. Regardless of the surgical technique or process usually employed by respondent, during the term of this probation respondent is required by this order to use standard aseptic technique for all podiatric procedures undertaken by respondent or anyone else at his direction.

5. During the term of this probation, respondent shall advance his podiatric training by successfully completing courses in the following areas at his expense: surgery; anesthetics; aseptic technique. Any such course taken by respondent to satisfy this requirement must be approved in writing, in advance, by this panel. Any courses proposed by respondent to fulfill these requirements must be proposed at least two months before the commencement date for the course.

6. If, during the first year of this probation, no negative report from observers is received and the supplemental education required by this order is concluded to the satisfaction of this panel, the probation of respondent will be terminated by the panel. The panel may, however, extend the probation term as necessary for the protection of the public.

7. If, during the term of this probation, the panel receives any report regarding respondent that is deemed negative to the respondent by the panel, including without being limited to any report indicating the occurrence of an act or omission that constitutes substandard podiatric care for this community or any report indicating a failure by respondent to conform his actions to the requirements of this order, the panel may order that respondent appear before it and show cause why his probation should not to be terminated and his podiatry license placed on suspension or revoked. At any such show cause proceeding the Colorado Medical Practice Act, 12-36-101, C.R.S. (1978, 1983 Supp.), the Colorado Podiatric Practices Act, 12-32-101, C.R.S. (1978, 1983 Supp.), and the Colorado Administrative Procedures Act, 24-4-101, C.R.S. (1973, 1983 Supp.) will guide the panel in its deliberations. Respondent may appear, with counsel if desired, and may put forth such evidence and argument as he or his counsel deem appropriate. The Office of the Colorado Attorney General may also appear and put forth such evidence and argument as is deemed appropriate. At the conclusion of any such show cause proceeding, the panel may issue a written order indicating the disposition being made of the matter. Such an order, if issued, shall be appealable to the Colorado Court of Appeals just as any other final order of the Medical Board. *See:* 12-36-119(2), C.R.S. (1983 Supp.).

8. The provisions of paragraph seven, above, shall not replace or repeal the standard discipline proceedings set out in 12-36-117 and 118, C.R.S. (1978, 1983 Supp.) or in 12-32-107, C.R.S. (1978, 1983 Supp.). Rather, a show cause proceeding ordered by the Hearings Panel shall be

paralell (sic) to any other discipline, investigation or proceeding commenced with respect to respondent.

Dated this 10th day of May, 1984.

COLORADO STATE BOARD OF
MEDICAL EXAMINERS-PANEL B

By /s/ John S. Carroll
Acting Chairman

EXHIBIT A

Submitted as a part of Supplemental Order of Panel B., State Board of Medical Examiners:

PEOPLE
OF THE STATE OF COLORADO *ex rel.*
DUANE WOODWARD, Attorney General,
Complainant,

v.

LENORD S. HORWITZ, D.P.M.,
Respondent.

The following named podiatrists have indicated a willingness to act as observers under the terms and conditions of the Supplemental Order in the above cited matter and are hereby designated as such.

Edward Ballow, D.P.M.

Jay Dworkin, D.P.M.

David Holz, D.P.M.

Ronald Green, D.P.M.

CERTIFICATE OF SERVICE

This is to certify that I have duly served the within SUPPLEMENTAL ORDER OF HEARING PANEL B upon all parties herein by depositing copies of same in the United States mail, postage prepaid, at Denver, Colorado this 10th day of May 1984, addressed as follows:

Lenord Horwitz, D.P.M.
5110 W. 38th Avenue
Denver, CO 80212

Jordan Hochstadt, Esq.
2043 York Street
Denver, CO 80205

Tom Lyons, Esq. (Interoffice Mail)
1525 Sherman Street, 2d Floor
Denver, CO 80203

Yolanda D. Hernandez

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Proceeding No. RG ME DAAED

AMENDMENT TO SUPPLEMENTAL ORDER—HEARING PANEL B APPOINTMENT OF SUBSTITUTE OBSERVERS

PEOPLE OF THE STATE OF COLORADO *ex rel.* DUANE WOODARD, ATTORNEY GENERAL,

Complainant,

vs.

LENORD S. HORWITZ, D.P.M.,

Respondent.

Hearing Panel B hereby amends its Supplemental Order of May 10, 1984, for the purpose of appointing substitute observers due to the failure of acceptance of three of the four observers originally designated.

The Panel hereby deletes subparagraph a. of paragraph 3 of the Supplemental Order and substitutes the following therefor:

> a. The podiatric practice of the respondent shall be observed by the following named individuals who have indicated their agreement to observe:
>
> Dr. Jay Dworkin — D.P.M. — Exhibit A
> Dr. Lawrence Varner — D.O. — Exhibit B
> Dr. Terry Wintory — D.O. — Exhibit C
> Dr. William Winter — M.D. — Exhibit D

In the event less than all are able or willing to serve or continue serving as observers, the remaining individuals may agree to continue as such.

It is the professional opinion of the Panel that all four of the above appointees are well qualified to observe and apply the required standard of care to the respondent's practice of podiatry. Although the majority of the observers are not podiatrists, the three latter named doctors are qualified orthopedic surgeons with specific expertise and familiarity regarding the practice of podiatry. The observational standard shall be as stated in paragraph 7 of the Supplemental Order and shall be the standard of podiatric care in this community.

The Panel directs the representative of the Attorney General's Office who has acted as attorney for the complainant to properly notify the Court of Appeals of the above action.

DATED this 10th day of July, 1984.

COLORADO STATE BOARD OF
MEDICAL EXAMINERS
(PANEL B)

Christine Peterson
MEMBER

Stephen R. Kozloff
MEMBER

F. R. Pacquette
MEMBER

MEMBER

EXHIBIT A

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS, STATE OF COLORADO

Proceeding No. RG ME DAAED

AGREEMENT TO SERVE AS A HEARINGS PANEL OBSERVER

PEOPLE OF THE STATE OF COLORADO, *ex rel.* DUANE WOODARD, Attorney General,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

I, Jay Harvey Dworkin, DPM state that I do agree to serve Hearings Panel B of the Colorado State Board of Medical Examiners in the capacity of an observer of the podiatric practice of Lenord S. Horwitz, D.P.M. I further state that I read and am aware of the Findings of Fact, Conclusions of Law and Order of that Hearings Panel, issued May 1, 1984, as well as the Supplemental Order of that Panel, issued May 10, 1984. The role of observer described in those orders is understood by me and I will endeavor to fulfill that role to the best of my ability in accordance with the terms set out therein.

/s/ Jay Harvey Dworkin
Signature

EXHIBIT B

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS, STATE OF COLORADO

Proceeding No. RG ME DAAED

AGREEMENT TO SERVE AS A HEARINGS PANEL OBSERVER

PEOPLE OF THE STATE OF COLORADO, *ex rel.* DUANE WOODARD, Attorney General,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

I, Lawrence Norman Varner, D.O. state that I do agree to serve Hearings Panel B of the Colorado State Board of Medical Examiners in the capacity of an observer of the podiatric practice of Lenord S. Horwitz, D.P.M. I further state that I read and am aware of the Findings of Fact, Conclusions of Law and Order of that Hearings Panel, issued May 1, 1984, as well as the Supplemental Order of that Panel, issued May 10, 1984. The role of observer described in those orders is understood by me and I will endeavor to fulfill that role to the best of my ability in accordance with the terms set out therein.

/s/ Lawrence Norman Varner
Signature

EXHIBIT C

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS, STATE OF COLORADO

Proceeding No. RG ME DAAED

AGREEMENT TO SERVE AS A HEARINGS PANEL OBSERVER

PEOPLE OF THE STATE OF COLORADO, *ex rel.* DUANE WOODARD, Attorney General,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

I, Terry Joel Wintory, D.O. state that I do agree to serve Hearings Panel B of the Colorado State Board of Medical Examiners in the capacity of an observer of the podiatric practice of Lenord S. Horwitz, D.P.M. I further state that I read and am aware of the Findings of Fact, Conclusions of Law and Order of that Hearings Panel, issued May 1, 1984, as well as the Supplemental Order of that Panel, issued May 10, 1984. The role of observer described in those orders is understood by me and I will endeavor to fulfill that role to the best of my ability in accordance with the terms set out therein.

/s/ Terry Joel Wintory, D.O.
Signature

EXHIBIT D

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS, STATE OF COLORADO

Proceeding No. RG ME DAAED

AGREEMENT TO SERVE AS A HEARINGS PANEL OBSERVER

PEOPLE OF THE STATE OF COLORADO, *ex rel.* DUANE WOODARD, Attorney General,

Complainant,

v.

LENORD S. HORWITZ, D.P.M.,

Respondent.

I, Wm. Gordon Winter, Jr., MD state that I do agree to serve Hearings Panel B of the Colorado State Board of Medical Examiners in the capacity of an observer of the podiatric practice of Lenord S. Horwitz, D.P.M. I further state that I read and am aware of the Findings of Fact, Conclusions of Law and Order of that Hearings Panel, issued May 1, 1984, as well as the Supplemental Order of that Panel, issued May 10, 1984. The role of observer described in those orders is understood by me and I will endeavor to fulfill that role to the best of my ability in accordance with the terms set out therein, with modifications as decreed by the court on 7/13/84 and verbally discussed with Mr. J. Riley.

/s/ Wm. Gordon Winter, Jr., MD
Signature

CERTIFICATE OF SERVICE

I, Thomas J. Beckett, Program Administrator to the Colorado Board of Medical Examiners, on July 24, 1984, placed in the U.S. Mail, postage prepaid, the attached Amendment to the Supplemental Order of Hearing Panel B, Appointment of Substitute Observers, issued July 20, 1984, in proceeding no. RG ME DAAED, addressed as follows:

Lenord Horwitz, D.P.M. (certified mail return receipt requested)
5110 W. 38th Avenue
Denver, CO 80212

Jordan Hochstadt, Esq.
2043 York St.
Denver, CO 80205

/s/ Thomas J. Beckett

APPENDIX I

C.R.S. § 24-4-105

* * *

(14) For the purpose of a decision by an agency which conducts a hearing or an initial decision by a hearing officer, the record shall include: All pleadings, applications, evidence, exhibits, and other papers presented or considered, matters officially noticed, rulings upon exceptions, any findings of fact and conclusions of law proposed by any party, and any written brief filed. The agency or hearing officer may permit oral argument. No ex parte material or representation of any kind offered without notice shall be received or considered by the agency or by the hearing officer. The agency or hearing officer, with the consent of my parties, may eliminate or summarize any part of the record where this may be done without affecting the decision. In any case in which the agency has conducted the hearing, the agency shall prepare, file, and serve upon each party its decision. In any case in which a hearing officer has conducted the hearing, the hearing officer shall prepare and file an initial decision which the agency shall serve upon each party, except where all parties with the consent of the agency have expressly waived their right to have an initial decision rendered by such hearing officer. Each decision and initial decision shall include a statement of findings and conclusions upon all the material issues of fact, law, or discretion presented by the record and the appropriate order, sanction, relief, or denial thereof. Each promulgation of rules shall be in accordance with the requirements of section 24-4-103(4). In the absence of an appeal to the agency by filing exceptions within thirty days after service of the initial decision of the hearing officer upon

the parties, unless extended by the agency, or a review upon motion of the agency within thirty days after service of the initial decision of the hearing officer, every such initial decision of a hearing officer shall thereupon become the decision of the agency. In such case the evidence taken by the hearing officer need not be transcribed.

(15) (a) Any party who seeks to reverse or modify the initial decision of the hearing officer shall promptly file with the agency a designation of the parts of the transcript of the proceedings which shall be prepared and advance the cost therefor. A copy of this designation shall be served on all parties. Within ten days thereafter, any other party or the agency may also file a designation of additional parts of the transcript of the proceedings which is to be included and advance the cost therefor. The transcript or the parts thereof which may be designated by the parties or the agency shall be prepared by the reporter or, in the case of an electronic recording device, the agency and shall thereafter be filed with the agency. No transcription is required if the agency's review is limited to a pure question of law. The agency may permit oral argument. The grounds of the decision shall be within the scope of the issues presented on the record. The record shall include all matters constituting the record upon which the decision of the hearing officer was based, the rulings upon the proposed findings and conclusions, the initial decision of the hearing officer, and any other exceptions and briefs filed.

(b) The findings of evidentiary fact, as distinguished from ultimate conclusions of fact, made by the hearing officer shall not be set aside by the agency on review of

the hearing officer's initial decision unless such findings of evidentiary fact are contrary to the weight of the evidence. The agency may remand the case to the hearing officer for such further proceedings as it may direct, or it may affirm, set aside, or modify the order or any sanction or relief entered therein, in conformity with the facts and the law.

(16) Each decision and initial decision shall be served on each party by personal service or by mailing by first-class mail to the last address furnished the agency by such party and shall be effective as to such party on the date mailed or such later date as is stated in the decision.

Source: L. 59, p. 162, § 4; C.R.S. 53, § 3-16-4; L. 61, p. 138, § 1; C.R.S. 1963, § 3-16-4; L. 69, p. 85, § 5; L. 76, pp. 583, 584, §§ 16, 17; L. 77, pp. 1137, 1145, §§ 2, 2; L. 81, p. 1134, § 3.